State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.4 Overview of the State

During 1999 and 2000, in anticipation of the FY2001 MCH Block Grant application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions, and professional judgement from those working in the field. The needs assessment process and resulting priorities are more fully described in Section 3.1 and will be used to guide Ohio's MCH Block Grant-funded activities and grant applications for the next five years.

Ohio's Title V Program provides the linkage among the many constructs that impact programs for the maternal and child population. Required MCH core performance measures are evaluated against the results of the state's needs assessment priority areas; State Child Health Insurance Program and other welfare reform programs are directly related to the health care services provided by the Title V Program; and political initiatives such as Ohio Family and Children First and the Ohio Department of Health's Strategic Planning Priorities also must inter-relate with the activities funded through the MCH Block Grant.

Ohio's Title V Program is able to work within these programs and initiatives and has become more efficient and responsive to the needs of the MCH population. Local programs that receive Title V funds are familiar with MCH Block Grant performance measures and prepare their grant applications to ODH by population group and level of the service pyramid, based upon their own county-level needs assessment. Title V dollars expended on direct service at the local level augment the publicly-funded safety net. Medicaid and other third party payors are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services.

In Ohio, 81% of the population lives in metropolitan areas. Pockets of inner city poor and the 19% of the population living in rural areas lack access to primary health care services. Access to specialists is often non-existant. Ohio's MCH Block Grant application is focused on assuring that services are available and accessible to women and children. Last year, 18,801 pregnant women were served through Title V-funded prenatal clinics (approximately 12% of live births) and nearly 60,000 children were seen in Title V-funded child health clinics. As part of a department-wide strategic plan, the MCH Block Grant will be joining efforts to reduce health disparities in and promote access to primary health care services. Activities to assist eligible women and children in the enrollment of expanded Medicaid programs will be supported. Providers will be recruited to become Medicaid providers, especially dentists. Primary prevention activities will be conducted. And, outreach workers will be provided to work within high-risk neighborhoods to identify and assist pregnant women and mothers. There is a concerted effort to mesh priorities identified through the needs assessment with priorities determined by the state agency and collaborate intervention efforts.

1.5.1.1 Organizational Structure

Director J. Nick Baird, M.D., of the Ohio Department of Health (ODH) is one of twenty-six directors or appointees who serve at the pleasure of Governor Bob Taft. Governor Taft is currently in the second year of his first term as Governor of Ohio. Dr. Baird, an obstetrician-gynecologist who has been with the ODH for one year, has extensive experience working as an administrator within a large health care system.

The ODH remains organized by function with nearly all programs in the department housed within three divisions. Maternal and Child Health (MCH) funded programs and positions (including the state's Children with Special Health Care Needs Program) are under the supervision of the Ohio Title V Director, Kathryn K. Peppe, R.N., M.S., Chief of the Division of Family and Community Health Services (DFCHS). The Division of Prevention, one of the other two divisions within the department, receives limited Title V MCH Block Grant funding for the Women's Health Program. All three divisions within the ODH are under the supervision of the Assistant Director of Health who has in the past worked with the administration of the MCH Block Grant, served as Chief of the Bureau of WIC and as an advocate with the Ohio Office of the Children's Defense Fund. Recently appointed Chief Fiscal Officer of the ODH is a former DFCHS fiscal administrator experience with the MCH Block Grant.

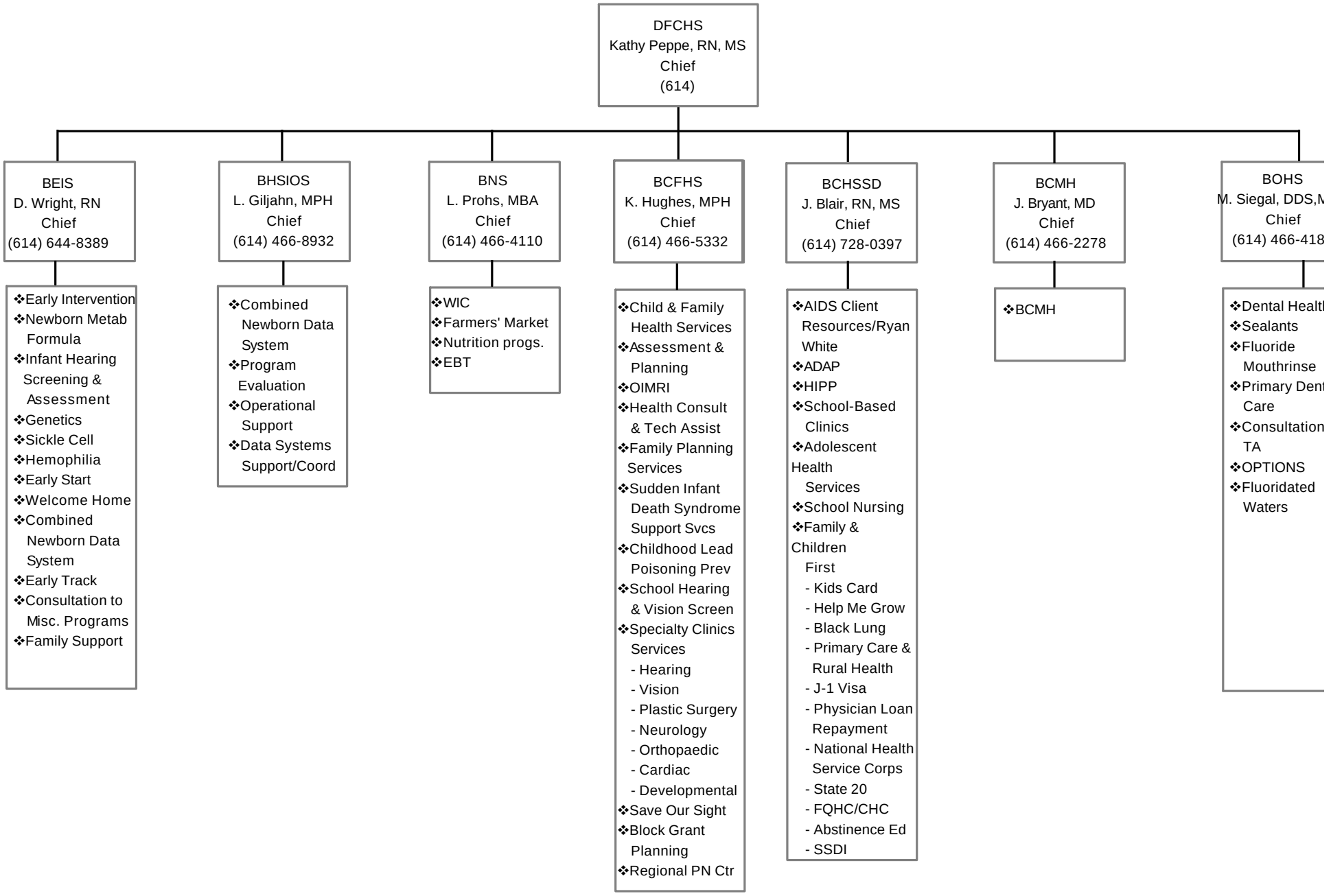
Ms. Peppe directs the work of the following seven bureaus:

- Bureau of Child & Family Health Services (BCFHS)
- Bureau for Children with Medical Handicaps (BCMH)
- Bureau of Community Health Services and Systems Development (BCHSSD)
- Bureau of Early Intervention Services (BEIS)
- Bureau of Health Services Information and Operational Support (BHSIOS)
- Bureau of Nutrition Services (BNS)
- Bureau of Oral Health Services (BOHS)

For a listing of the programs housed within each bureau, see the following charts.

The MCH Advisory Council assists the Division of Family and Community Health Services by advising on block grant funded programs and the population served by the Title V Program. The council is composed of maternal and child health professionals in both the public and private sectors, clinicians, administrators, policy makers, MCH advocates, consumers, state agency representatives, academicians and state legislators. They are appointed by the Director of Health.

Division of Family and Community Health Services



1.5.1.2 Program Capacity

The following is a description of preventive and primary health care services for pregnant women, mothers, infants, and children, including children with special health care needs provided through Ohio's Title V agency.

Bureau of Child and Family Health Services (BCFHS)

The BCFHS funds, monitors and evaluates the Child and Family Health Services Program (CFHSP) which provides family planning, prenatal and child health clinical services in 81 of Ohio's 88 counties. Local programs are visited regularly by Title V program staff and are provided technical assistance on issues ranging from project administration, delivery of clinical services, confidentiality, Medicaid enrollment, working with managed care organizations, community health needs assessment, program planning and evaluation. Last year, 281,508 visits were made by 93,743 clients to CFHS clinics.

During FY2000, Regional Perinatal Education Centers (RPECs) transferred from the ODH Division of Quality, to the Division of Family and Community Health Services. The RPECs, multi-disciplinary teams from tertiary care centers, are funded through Title V to provide technical assistance on clinical services to local prenatal providers, especially those funded by Title V.

The Ohio Infant Mortality Reduction Initiative (OIMRI) utilizes Title V funds to provide one-on-one case management and support services to at-risk pregnant women living in targeted areas with the highest infant mortality rates in Ohio. The community outreach workers work with women to facilitate access to prenatal care, and to assist women in improving their parenting skills. Outreach workers continue their involvement with a family until the child is two years old.

Specialty Clinics for children are provided in 52 counties in Ohio. The seven types of clinics, Cardiac, Developmental Delay, Hearing, Neurology, Orthopedic, Plastic Surgery and Vision, improve access to pediatric specialists in medically underserved areas. Both diagnosis and treatment services are provided through these itinerant clinics. Public Health Nurses at the local clinics assist families in applying for Medicaid and BCMH and help families make follow-up appointments for other testing or surgery.

The CDC supported Childhood Lead Poisoning Prevention Program funds its Regional Lead Resource Centers by using Title V funds to provide technical assistance to local providers (clinics, physician offices, etc.) and families on the importance of screening and public awareness of this health issue. The program works closely with other divisions within the ODH where certified lead abatement work is conducted. This completes the continuum of medical case management, environmental home inspections, identification of lead sources, and then abatement of the lead sources.

The Save Our Sight (SOS) Program, funded through voluntary donations by Ohioans at the time of vehicle registration, provides over five hundred thousand dollars annually in grant funds to promote early detection of eye problems, eye safety and vision conservation programs for children.

Bureau for Children with Medical Handicaps

Ohio's BCMH Program continues to provide funding and ongoing support services to children with special needs and their families through its diagnostic, treatment and care coordination programs. Families are assisted through either the direct payment of approved health care bills by BCMH for services rendered by approved providers, or through BCMH's payment of health insurance premiums. The diagnostic program enables any child with a suspected handicapping condition to receive consultation or diagnostic testing, regardless of family income. The treatment program provides a third party pay source for medical services for financially qualified children with eligible handicapping conditions. The care coordination program provides public health nursing services to families in an effort to assist them in understanding their child's condition, the special needs they may have, and in liaison with the family's medical providers. There is close coordination of BCMH services with Medicaid and other third party payors; BCMH is the payor of last resort.

The state Title V program for CSHCN provides rehabilitation for blind and disabled individuals under the age of 16 receiving Social Security Income (SSI). Although, in Ohio, these children are not automatically enrolled for Title XIX (Medicaid) benefits, they are financially eligible to receive BCMH benefits. BCMH may provide rehabilitation services for eligible children and coordinates with other agencies to assure that children receive needed services. Additionally, BCMH sponsors educational programs for parents and professionals regarding obtaining and maintaining Title XIX benefits.

Promotion of family-centered, community-based, coordinated care for children with special needs occurs in several ways. The BCMH Service Coordination Program links tertiary care center team coordinators, families and local services coordinators (i.e., public health nurses) together to develop a comprehensive service plan to address the needs of the child and family. The BCMH Advisory Council meets regularly with the BCMH Chief and Parent Consultant to obtain current BCMH information and review BCMH plans and concerns related to the care and service provided by the CSHCN Program. Additionally, BCMH provides opportunities for other agencies such as the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) to meet with the Parent Advisory Committee (PAC) to share information, concerns and future plans.

Bureau of Community Health Services and Systems Development

School nursing consultation and adolescent health programs are Title V-funded programs housed in this bureau. Other Programs, funded through non-Title V sources include abstinence-only education programs;

the Ryan White AIDS Care Program; Primary Care and Rural Health and related programs to impact health provider shortages. These programs provide many services to women and children in Ohio and are collaborative with the MCH Block Grant and other Division of Family & Community Health Services initiatives.

The ODH school nurse consultant provides consultation, technical assistance and facilitates continuing education opportunities for school nurses through annual statewide and regional conferences. School nursing programs provide preventive screenings for hearing, vision and scoliosis and ensure that students are up to date on their immunizations. A statewide Adolescent Health Advisory Committee advises the Ohio Department of Health on priority issues that impact the health of adolescents and suggest program focus. In addition, 29 Abstinence Only Education grants are administered in this bureau using funds from the federal MCHB.

Bureau of Early Intervention Services (BEIS)

The BEIS administers nine programs to promote early identification and intervention services for young children. Most of the programs are funded through sources other than the MCH Block Grant, such as state General Revenue Funds (GRF) and the U.S. Department of Education. BEIS administers the Part C Early Intervention Program, Ohio Early Start (services for at-risk children 0-3), the Welcome Home Newborn Visitation Program, and coordinates these programs with MCH Block Grant programs. The Regional Genetics Centers, and Regional Sickle Cell Centers provide consultation, education, and treatment services to families and are funded primarily through the sale of newborn screening kits in Ohio. A declining birth rate, and improved testing methods have decreased the amount of funding realized through the newborn screening kits. Both genetics and sickle cell programs, as well as the Metabolic Formula Program are partially funded by the MCH Block Grant.

The BEIS also administers the Health Systems Development in Child Care (HSDCC) grant for health consultation in child day care; the Infant Hearing Program and the Hemophilia Program. Legislation proposed in Ohio is being monitored by ODH staff which would require a universal newborn hearing screening. ODH staff have also provided consultation to the Legislature and interested others about universal newborn hearing screening programs. The Hemophilia Program provides education, family support, and insurance premium payments for patients with Hemophilia or other related bleeding disorders. The program also provides clotting factor products for patients with no other source of paying for these services.

Bureau of Health Services Information and Operational Support (BHSIOS)

The BHSIOS provides support services to all program areas within the Division of Family and Community Health Services. The Research and Evaluation section provides data analysis, program planning and

evaluation assistance through the utilization of epidemiologists and program analysts. Other sections within the BHSIOS provide grants processing support and purchasing/fiscal support to Division programs as well as the technological support of computer-based data collection systems.

Bureau of Nutrition Services (BNS)

The BNS administers primarily the State's WIC Supplemental Food and Nutrition Program for Women, Infants and Children. Since the target population for the WIC Program, and other Title V funded programs is the same, there is extensive collaboration on initiatives such as breastfeeding promotion, maximizing immunization opportunities, and assisting families in applying for Medicaid/CHIP.

Bureau of Oral Health Services (BOHS)

The BOHS supports local agencies with grant funding to provide dental care services (primary care and dental sealants) to high risk children and women of childbearing age. The Bureau also develops program and training materials and provides technical assistance and monitoring to other Division of Family & Community Health Services programs such as BCFHS clinics, BNS, Head Start, local schools and other public health related programs. Communities are assisted in conducting oral health needs assessments and developing sites for providing primary dental care services. This assistance includes making application for federal designation as a Dental Health Professional Shortage Area.

The BOHS improves access to dental health care through the OPTIONS Program (Ohio Partnership to Improve Oral Health through access to Needed Services). The program links uninsured, low income patients with safety net dental programs, or a network of dentists who agree to either donate or significantly discount their fees.

1.5.1.3 Other Capacity

Nearly 200 positions within ODH are either fully or partially supported by the MCH Block Grant. Sixteen of these positions are housed in ODH District Offices; the rest are Central Office-based in Columbus.

Currently there are two parents of children with special health care needs employed at ODH. One is in the Bureau of Early Intervention Services and oversees grants and activities that are focused on family-centered services. The second parent works in the Bureau for Children with Medical Handicaps as a family advocate and established the BCMH Family Advisory Committee. She works as a liaison between families and BCMH. She provides information about BCMH to families, and brings families' issues to BCMH Program leadership.

Brief biographies of Division of Family and Community Health Services leadership:

Division of Family and Community Health Services

Kathryn K. Peppe

Job Title: Division Chief

Degree(s): B.S. Nursing, M.S. Pediatric Nursing Education, F.A.A.N., F.A.A.M.R.

Experience: 8 years Division Chief; President, Association of Maternal and Child Health Programs (AMCHP); 3 years Assistant Division of Maternal and Child Health Chief; 14 years DMCH Administrative Staff Nursing Consultant, including various acting positions: Child Health Unit Supervisor, Genetics Project Director, BCMH Medical Case Management Supervisor and Early Intervention Supervisor, 4 years Nurse Instructor in a university affiliated program for MR/DD.

Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and other State agencies; and manages the daily operation of the Division.

Virginia A. Haller

Job Title: Medical Director, DFCHS

Degree(s): B.A. Biology, Music; M.D., F. A. A. P.

Experience: 1.5 years Medical Director, DFCHS; 8 years Clinical Associate Professor of Pediatrics, OSU; 7 year member Franklin Co. Alcohol, Drug Abuse and Mental Health Services Board; 1.5 years Medical Director, Ohio Department of Health; 2.5 years Medical Director, United HealthCare of Ohio, Inc.; 7 years, Chief and Medical Consultant, Bureau of Maternal and Child Health; 1 year Chair of Ohio Task Force on Drug Exposed Infants.

Duties: Formulates medical policy as advisor to the Division Chief, represents the Division and the Department on issues related to family and community health services. Lectures on pediatric and public health topics; serves as Divisional liaison with ODH Immunization Program in Division of Prevention, coordinates medical resident and student rotations with DFCHS.

Bureau of Child and Family Health Services

Karen Hughes

Job Title: Bureau Chief

Degree(s): B.S. Education; R.D.H.; M.P.H.

Experience: 9 years BCFHS Chief; 1 year, Acting Chief, Bureau of Maternal and Child Health; 1 year Assistant Chief, Bureau of Dental Health; 1 year Acting Chief, Bureau of Dental Health;

	4 years Program Administrator, Bureau of Dental Health; 3 years Public Health Dental Consultant; 3 years District Dental Consultant.
Duties:	Directs the Bureau of Child and Family Health Services programs including Family Planning; Perinatal and Child Health; Childhood Lead Poisoning Prevention; Pediatric Specialty Clinics; Ohio Infant Mortality Reduction Initiative; SIDS; and Save Our Sight to assure that low income children and families receive comprehensive public health and clinical services.

Bureau for Children with Medical Handicaps

James Bryant

Job Title:	Bureau Chief and Medical Director
Degree(s):	B.S. Biology; M.D.; F.A.A.P.; Pursuing masters degree in medical management
Experience:	20 years general practice of pediatric medicine with emphasis on CSHCN; 17 years full-time and continuing clinical practice part-time for past 5 years; 5 years Chief and Medical Director of BCMH; Associate Professor of Pediatrics, Wright State University School of Medicine; Faculty member Title V CSHCN Institute.
Duties:	Develop standards, implement programs and direct the CSHCN program; supervise state CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues.

Bureau of Community Health Services and Systems Development

Jamie Blair

Job Title:	Bureau Chief
Degree(s):	B.S. Nursing; M.S. Psychiatric and Mental Health Nursing
Experience:	2 years BCHSSD Chief; 4.5 years Certified Community Health Nursing Specialist, 10 years certified in pediatrics and 1.5 years certified as nurse case manager; 26 years of progressive experience including: program development, strategic planning, health care delivery, patient assessment, case management, research and evaluation, patient advocacy and standards development and training.
Duties:	Directs the assessment, planning, implementation and evaluation of statewide programs including Primary Care and Rural Health, Black Lung, AIDS Client Resources, School and Adolescent Health Services, Abstinence Only Education, Help Me Grow and the activities of the Strategic Planning Section.

Bureau of Early Intervention Services

Debbie Wright

Job Title: Bureau Chief

Degree(s): B.S. Nursing; M.S. Nursing Administration

Experience: 14 years nursing experience with obstetrics, neonatal and pediatric population; 2 years public health nursing; 1 year Bureau Chief; 4 months acting Bureau Chief; 4-1/2 years administrator Newborn Screening, Hemophilia, Sickle Cell and Genetics Programs; 2 years genetics and newborn screening nurse consultant.

Duties: Directs the planning, development, implementation and evaluation of the following bureau programs: Early Intervention (Part C); Ohio Early Start; Infant Hearing Screening; BabyNet High Risk Identification and Referral; Newborn Metabolic Screening; Metabolic Formula; Genetics, Sickle Cell, Hemophilia, Family Information Network, and the Welcome Home Programs.

Bureau of Health Services Information and Operational Support

Lynn Giljahn

Job Title: Bureau Chief

Degree(s): B.S. Medical Technology; M.P.H. Infectious Disease Epidemiology

Experience: Data Coordinator, Division of Maternal and Child Health; Bureau Chief, Division of Family and Community Health Services

Duties: Directs BHSIOS which provides support to all other DFCHS bureaus in research and evaluation, information systems and operational support.

Bureau of Nutrition Services

Larry Prohs

Job Title: Bureau Chief

Degree(s): M.B.A.

Experience: 10 years BNS Chief; 5 years Assistant Chief, Illinois Department of Public Health, Health Promotion & Screening (WIC), 7 years National Association of WIC Directors (NAWD) Board of Directors, 4 years NAWD Treasurer.

Duties: Directs and supervises the Bureau of Nutrition Services serving approximately 250,000 eligible WIC participants in Ohio; the Farmer's Market Nutrition Program; and an Electronic Benefits Transfer system used by participants in both programs.

Bureau of Oral Health Services

Mark Siegal

Job Title: Bureau Chief

Degree(s): D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health

Experience: 13 years Chief; 2 years Columbus City Health Department Dental Director; 4 years Hospital Director for Pediatric Dental Services; 4 years New Mexico Health District Dental Director.

Duties: Directs the Bureau of Oral Health Services' activities toward improving the oral health of Ohioans by assessing needs, implementing community-based disease prevention and health promotion and increasing access to dental care. Maintains a liaison role with professional associations and other agencies on policy development and other collaborative efforts.

1.5.2 State Agency Coordination

The DFCHS, through its seven bureaus, is responsible for the administration and implementation of many maternal and child health programs funded from sources other than Title V. The BCFHS houses the Title X Family Planning Program and the Centers for Disease Control and Prevention's Childhood Lead Poisoning Prevention Program. The BCHSSD administers the Primary Care and Rural Health Program which provides funding for primary care services, especially in medically underserved rural areas, and attempts to place health practitioners in rural areas; the Black Lung Disease Program; and the AIDS Client Resources Program which provides funding for health care and support systems to the community from the Ryan White Care Act. In addition, the BCHSSD also administers Ohio's Help Me Grow Program which promotes outreach to women to seek early prenatal care and preventive health care for their young children. BEIS administers the Early Intervention Program for infants and toddlers, the Ohio Early Start Program, the Welcome Home Program for home visits to first time and teen moms, and the state's Genetic, Sickle Cell and Hemophilia programs. The BNS is responsible for implementing Ohio's WIC Program and the Farmers Market Nutrition Program. All of these programs target much of the same population group(s) for services and are coordinated through their administration in the Division of Family and Community Health Services. Since bureaus within DFCHS are responsible for administering these MCH-related programs, close coordination with MCH Block Grant programs occurs. DFCHS has approximately 47 different funding sources supporting its many public health service programs.

The Ohio Family and Children First (OFCF) is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. This partnership is critical because no single state system has the resources or capacity to meet this goal alone. Oversight of the initiative is provided by the Family and Children First Cabinet Council. Members of the Cabinet Council include the State Superintendent of

Public Schools, and the Directors of the Departments of Alcohol and Drug Addiction Services; Budget and Management; Health; Job and Family Services (formerly Human Services); Mental Health; Mental Retardation and Developmental Disabilities; Aging; and Youth Services. The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities.

The Cabinet Council recognizes that to succeed the initiative must be "home grown", and as such, all 88 Ohio counties have created a Family and Children First Council. Local council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness. The state, however, has identified two core strategies under which interdepartmental efforts are organized. These are:

- Community-based partnerships; and
- Literacy and 4th grade reading guarantee.

Since February 1995, DFCHS has operated the Help Me Grow (HMG) help line, a statewide toll-free 800 number, which provides health and social service referrals and information to callers and is also the toll-free number for Title V programs. Information on programs from the following state agencies is currently available: Aging; Alcohol and Drug Addiction Services; Education; Health; Jobs and Family Services; Mental Health; and Mental Retardation and Developmental Disabilities, as well as local sites for clinical services. The HMG Program has created a free wellness guide offering expectant and new mothers step-by-step health information to encourage regular prenatal care and primary care for their children. The long term goal of the HMG helpline is to replace many of the state's current 800 numbers, allowing for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families and children. During FY99, the HMG help line received 42,838 calls of which 25,865 were transferred or referred to BCMH. The HMG help line is available to callers twenty-four hours a day, seven days a week. Between the hours of 8:00 am to 8:00 pm Monday through Friday and noon to 5:00 pm on Saturday and Sunday, calls are answered by a live operator. During other hours, callers leave their messages on an automated voice mail system to order their wellness guide or other packets of information. Weekly and monthly reports on calls received and referrals made are reviewed by state staff. Periodic evaluations of the help line are conducted to determine client satisfaction and outcome.

Ohio Kids Card provides families with children under six years of age with a card that may be used throughout Ohio for discounts on products and services. The goal of the Ohio Kids Card is to help ease the financial burden of raising children while providing positive child health and educational opportunities. The program is scheduled to be launched August 2000.

The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards and committees, and shares some committees with organizations. The Ohio Chapter of the American Academy of Pediatrics shares the Children with

Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social and educational issues of CSHCN in addition to medical issues.

The Immunization Unit in the Division of Prevention serves as the lead for statewide immunization services and develops the State Immunization Action Plan. In partnership with DFCHS-funded projects, DFCHS consultants cordinate and support statewide immunization compliance in CFHS and WIC clinics. The DFCHS Medical Director chairs the physician group which advises ODH on the recruitment of providers to participate in the statewide immunization registry. She also serves as liaison between ODH and the Ohio Chapter of the American Academy of Pediatrics (AAP) in regard to the immunization education program for physicians and nurses.

Technical assistance and training are provided by DFCHS nutrition, oral health, nursing, and hearing and vision consultants to state Head Start Programs in collaboration with the Ohio Head Start Association and the Ohio Department of Education (ODE). At the request of the Ohio Head Start Association and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration between the two programs in the areas of nutrition screening/assessment, education, referral, and recruitment has been signed.

The ODH has also recently entered into a written agreement with ODHS to provide Temporary Assistance for Needy Families (TANF) federal funds to help support Ohio's Early Start Program. The Early Start Program's goal is to promote child development and reduce child abuse and neglect by ensuring that services are coordinated for at-risk families and that children ages 0-3 years have adequate medical care.

The DFCHS Chief represented ODH on a statewide task force to review the child welfare system in Ohio and to make recommendations to the Director of the Ohio Department of Human Services (effective July 1,2000, ODHS will become the Ohio Department of Job and Family Services—ODJFS), for the improvement of the system. The review encompassed adoption programs, child abuse and neglect, child care and children's protective services.

DFCHS staff prepared a proposal for CHIP Outreach and Enrollment which was submitted by ODH to ODHS in December 1999. While ODHS has not approved the proposal to date, DFCHS staff meet regularly with Medicaid policy staff to work out issues of common interest. For example, Ohio's Combined Program Application form (used by Medicaid, CHIP, WIC, CFHS, and BCMH) is currently being revised and will be used by early intervention and Ohio Early Start Programs as well.

DFCHS staff serve on the ODHS Day Care Advisory Council, a legislatively mandated body that advises ODHS on child care policy and implementation of child care law. The BCMH Chief also represents the ODH, DFCHS on the Ohio Developmental Disabilities Planning Council. DFCHS staff serve on the Interagency Nutrition Committee of Ohio, made up of all USDA-funded agencies. Members coordinate USDA nutrition activities that currently include support of the USDA Team Nutrition Initiative for the Schools. The DFCHS Chief and BCFHS Chief also serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB. The DFCHS Medical Director sits on the Medicaid Medical Advisory Committee for the ODHS, and serves on the Executive Committee for that group.

BCHSSD staff serve on the ODE Literary Task Force, coordinate with the Ohio State University School of Public Health in the development of a Bio-nutrition Center and in developing a locus for maternal and child health in the School of Public Health's curriculum.

Maternal and Child Health Block Grant
Annual Report for Fiscal Year 1999

Progress on the Annual Performance Measures

All Ohio DFCHS funded projects are monitored by the central office and regional office staff. The monitoring includes ongoing data analysis, onsite survey of work plan progress, technical assistance and consultation. The DFCHS FY99 goal is to insure that Ohio is collecting data to determine its progress on the core performance measures and state negotiated measures.

Funded projects are required to collect standardized client process and outcome data. DFCHS data systems are in the following programs: BCFHS-MATCHr, the Ohio Infant Mortality Reduction Initiative (OIMRI), Childhood Lead Poisoning Program (STELLAR), Specialty Clinics Program, School Hearing and Vision Survey, BNC-WIC client tracking system, BCMH, BEIS-Early Track, BCHSSD-Help Me Grow Helpline Data system and BOH-Options.

The activities conducted to impact the core and state negotiated performance measures utilize strategies that affect the contributing factors for each indicator. Many strategies, such as decreasing smoking during pregnancy affect multiple performance measures and outcome measures. Thus, several activities conducted are efficient in their potential impact on more than one indicator.

<u>Direct Services</u>

Pregnant Women, Mothers and Infants

State Negotiated Performance Measure 1: The unintended pregnancy rate per thousand in women of childbearing age.

- The annual performance objective (target) for FY99 was 750 per 1,000 women of childbearing age.
- The annual performance indicator (actual) for CY98 was 840.2 per 1,000 women of childbearing age.

The annual performance measure was not met. Continued emphasis on serving the population at risk will bring this measure closer to the performance objective. Currently the data used to evaluate this measure are program-based. In the future, population-based data will be available via the Pregnancy Risk Assessment Monitoring System (PRAMS) to measure this indicator.

CFHS and Title X family planning clinics served 88,022 clients in 188,761 visits as compared to 81,131 clients in 186,065 visits in FY98.

Technical assistance was provided to 20 CFHS family planning projects on issues to improve clinic and administrative operations.

TANF funding was provided to 7 counties for family planning services, enabling more women and men to receive subsidized and accessible family planning services.

CFHS and Title X projects served 30,343 teen clients, increasing the availability and accessibility of family planning services to teen women at risk for unintended pregnancies.

Children

State Negotiated Performance Measure 7: Percent of children with obvious need for dental care.

- The annual performance objective (target) for FY99 was 23% of children.
- The annual performance indicator (actual) for FY99 was 25% of children.

The annual performance objective was not met. Providing oral health status data and resource information to communities; building the capacity of local agencies and health care providers to assess oral health needs and resource; building and enhancing the safety net dental care programs; and promoting optimally fluoridated drinking water all impact the percent of children with an obvious need for dental care.

Data on oral health status was collected in 336 elementary schools in Ohio. This survey found that 25 percent of third grade schoolchildren had an obvious need for dental care.

Only 23.8 percent of children ages 3-8 enrolled in Medicaid had a claim for a dental exam in FFY97. Therefore, most Medicaid-eligible children are not going to the dentist and have an obvious need for dental care.

Surveys on access to dental care were sent to Ohio dentists, dental safety net programs and low-income consumers to learn about barriers to accessing dental care. Data were collected for use in county-specific oral health profiles that will be distributed for use in local needs assessments.

BOHS staff provided resources and information on assessing the oral health needs of school children to 400 school nurses at five ODH-sponsored school nurse training sessions.

BOHS staff provided training and technical assistance to three CFHS and 21 Head Start programs to ensure compliance with oral health screening performance standards.

Eight Head Start programs participated in the Quality Dental Care Technical Assistance Project (QDC-TAP) to increase the percentage of enrollees with completed dental treatment.

BOHS received two grant awards from the: 1) U.S. Department of Health and Human Services, Health Resources and Services Administration for an Oral Health Integrated Systems Development for developing community-based oral health initiatives that improve access to dental care for Medicaid, CHIP and other vulnerable children; and 2) CDC to develop a plan for working with schools and communities to increase access to oral health education, prevention and treatment services for high-risk school-aged children.

The number of dental Health Professional Shortage Area (HPSA) designations was increased from 13 to 20. No dentists were placed in any HPSAs.

The fluoride mouth rinse program was provided to 60,081 students (in 257 schools) in fluoride-deficient and/or low-income areas or schools that limit enrollment to children with special health care needs.

Using OEPA data, BOHS maintained a database to generate the fluoridation report for CDC and to determine where fluoridating plants fall within the acceptable range of fluoridation.

Children with Special Health Care Needs

Performance Measure 1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

- The annual performance objective (target) for FY99 was 7% of SSI beneficiaries less than 16 years.
- The annual performance indicator (actual) for FY 99 was 5.4% of SSI beneficiaries less than 16 years.

The annual objective for FY99 was not met. BCMH will continue to work with SSA/BDD to match BDD's electronic eligibility file with that of BCMH's eligibility files. There continues to be a number of issues to be resolved such as privacy and technical issues.

BCMH enrolled 1,872 eligible children who received SSI benefits. BCMH receives a copy of a child's SSI application from the local Bureau of Disability Determination (BDD) when it appears that the child may be eligible for BCMH services.

Performance Measure 2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

- The annual performance objective (target) for FY99 was 9 types of services paid.
- The annual performance indicator (actual) for FY99 was 8 types of services paid.

The annual objective for FY99 was not met. Of the nine services on the checklist, BCMH pays for eight of them. BCMH does not cover home health care. However, BCMH does pay for public health nurses to perform home visits to assist families and their children with special health needs through care coordination. Budget restrictions prevent the BCMH Program to financially support home health services. The Early Intervention program covers some home health services for the age 0-3 population.

BCMH paid for eight of the nine specialty services: medical and surgical subspecialty services; occupational therapy; physical therapy; speech therapy; respiratory services; durable medical equipment and supplies; nutrition services; and care coordination without regard to income. The Early Intervention program, through the BCMH program, paid for diagnostic services for children less than three years of age without regard to income.

BCMH paid private insurance premiums for 34 recipients. BCMH spent approximately $65,000 for the premiums, which saved over $550,000 in treatment expenditures that otherwise would have been paid by BCMH.

BCFHS provided a statewide specialty clinic program for children that included cardiac, developmental delay, hearing, neurology, orthopedic, plastic surgery, and vision services to children in medically underserved areas of Ohio. 9,649 visits were made at 512 clinic sessions in 52 of Ohio's 88 counties. In addition, over 400 pairs of glasses were dispensed to medically underserved children through a private-public partnership with Vision Makers.

BCMH, through its multiple programs, provides diagnostic, treatment and service coordination services to over 35,270 clients.

Over 1025 individuals were trained in hearing and vision screening practices through formal conferences and informal training sessions.

State Negotiated Performance Measure 2: The rate per thousand of children and adults who receive genetic evaluation and counseling services through a Regional Comprehensive Genetic Center.

- The annual performance objective (target) for FY 99 was 17.6 per 1,000 population.
- The annual performance indicator (actual) for FY98 was 16.5 per 1,000 population.

The annual performance objective was not met. Several factors are associated with the objective not being met. First, FY98 was a transitional year as a new electronic genetics data collection system was implemented. Second, with decreased funding at a time of increased genetic technology and demand, the ability of projects to increase their services has been hampered. ODH will continue efforts to secure funding and improve the data reporting system specific to this performance measure.

The Regional Comprehensive Genetic Program (RCGP) funded 8 Genetics Centers that provided clinical services to 18,525 patients and their families with or at-risk for genetic disorders.

Approximately $1.3 million from the Newborn Screening Program fees were disbursed in the form of grants to the 8 RCGCs. This is approximately $100,000 less than the previous year. Genetic evaluation and counseling services are typically time intensive and often extended to underserved target populations, thus making them an expensive service to provide.

Enabling Services

Pregnant Women, Mothers and Infants

State Negotiated Performance Measure 6: Percent of women seen in the Ohio WIC program who stopped smoking between first and last visit.

- The annual performance objective (target) for FY99 was 4% of women in WIC who stopped or reduced smoking.
- The data for this annual performance indicator (actual) for FY99 was not available.

The data necessary to measure progress on this measure is currently under development. The Pregnancy Risk Assessment Monitoring System (PRAMS) program will allow the collection and analysis of data to support this measure during CY 2001.

DFCHS staff provided 13 training sessions for American Cancer Society's Fresh Start Smoking Cessation Program to CFHS Projects and 18 technical assistance visits to agencies implementing the Fresh Start Smoking Cessation Program.

The rate of tobacco use among CFHS perinatal clients rose slightly from 38.3% in FY98 to 38.7% in FY99.

The prenatal smoking cessation program completed development of a database that includes more than 20 variables**.**

The Help Me Grow Program designed a marketing program targeting health providers and consumers to reduce tobacco use. The marketing message is delivered via direct mailings and a media campaign (print, radio, TV).

The criteria for use of the WIC nutrition risk code for smoking changed. From October 1998 through March 1999, the criteria for use of the risk code for prenatal smoking was smoking greater than or equal to ½ pack of cigarettes per day during the current pregnancy. As of April 1999, the criteria for use of the risk for prenatal smoking are any cigarette use during the current pregnancy. Because of the change in the criteria for this risk code, a comparison cannot be made for the time period of October 1998 through September 1999.

State Negotiated Performance Measure 8: **Percent of women receiving adequate prenatal care according to Kotelchuk Index.**

- The annual performance objective (target) for FY99 was 47% of women with live births.
- The annual performance indicator (actual) for CY98 was 48.6% of women with live births.

The annual objective was met. DFCHS will continue efforts to implement program actions and develop outreach strategies for women who are not receiving adequate prenatal care to continually strive to improve this number.

The percent of all women receiving adequate prenatal care for CY98 was 48.6%, which is an increase from CY97 of 47.8%. CFHS prenatal projects provided 106,757 perinatal visits to 18,801 unduplicated clients.

CFHS staff used Kotelchuk Index (calculated by county and hospital) to analyze adequacy of prenatal care in CFHS and to target projects requiring further technical assistance.

MATCHr (CFHS data collection system) has been revised to list risk behaviors into pregnancy risk conditions and social/behavioral risk conditions, which will be collected at each client encounter.

Children

State Negotiated Performance Measure 5: The percentage of low-income children who are overweight.

- The annual performance objective (target) for FY99 was 8.8% of children in the WIC Program.
- The annual performance indicator (actual) for FY98 was 9.1% of children in the WIC Program.

The annual performance measure for FY99 was not met. Overweight status among young children continues to increase, and can be considered a social and environmental issue that is only partly under the control of the MCH program.

In order to monitor the growth of children, MATCHr (data system for CFHS clinics) WIC data and Pediatric Nutrition Surveillance System (PedNSS) data were reviewed before regularly scheduled CFHS site reviews to determine need for technical assistance.

In conjunction with consultation from Centers for Disease Control and Prevention, an in-house quality assurance system for WIC data, using PedNSS guidelines, has been developed. CFHS continues to monitor data outliers as a basis for problem identification and technical assistance.

CFHS provided technical assistance to projects with high percentages of children who were overweight.

The DFCHS, including WIC and CFHS, initiated a focus group on parenting skills to promote healthy eating and primary prevention of obesity. Materials for caregivers and providers are in development.

DFCHS collaborated with the Interagency Nutrition Committee of Ohio (includes representation from the ODH Bureau of Health Promotion and Health Risk Reduction, OSU Extension, OSU School of Public Health, and all USDA-funded state agencies) to act as a statewide workgroup to develop strategies to improve healthier eating in young children. Two statewide meetings were held to address childhood nutrition issues – one for issues of preschool-age children and one for issues of school-agers. The ideas generated in the meetings will be used to guide future planning efforts.

Children with Special Health Care Needs

Performance Measure 3: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

- The annual performance objective (target) was 100% of children in the BCMH Program.
- The annual performance indicator (actual) was 100% of children in the BCMH Program.

The annual performance objective was met. BCMH is working with the Ohio State University School of Public Health to develop estimates of the number of CSHCN in the state, as well as a number of other important health care measures. These will be used in FFY 2000 to develop a better understanding of the CSHCN population outside the universe served by BCMH. Currently, the only population data of CSHCN available to BCMH are its own which are used to complete this section. BCMH/BHSIOS will also be developing a survey to further measure this indicator. Current data are based on BCMH clients who report having a managing physician.

BCMH public health nurses help families navigate the healthcare system focusing on accessing care through the appropriate protocols required by various types of insurers.

BCMH requires each child that applies for the program to have a BCMH provider as managing physician. This managing physician performs a number of duties, including submitting the BCMH medical application required to determine medical eligibility; and serving as a medical home for the child, particularly when BCMH coverage is the sole third party payer on behalf of the family.

BCMH is working with the Ohio Chapter of the American Academy of Pediatrics to develop a pilot medical/health home program. This will allow BCMH to more accurately determine the proper medical/health home of their clients, and move closer to the MCH Block Grant's working definition of a medical/health home.

Population-Based Services

Pregnant Women, Mothers and Infants

Performance Measure 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies.

- The annual performance objective (target) for FY99 was 100% of newborns.
- The annual performance indicator (actual) for CY98 was 95% of newborns.

The performance objective was not met. The Ohio Revised Code allows parents to refuse testing based on religious tenets and practices.

Newborn Screening (NBS) literature was provided to all birth hospitals and birthing centers in Ohio. All parents are informed of the importance of having a NBS done prior to the infant's discharge and informed that a specimen needs to be collected after 48 hours of age if the infant was discharged early.

Ohio's NBS kit has been revised and distribution in spring of 2000 is anticipated.

Broad-based education to all health care providers has been implemented on how to complete the NBS kit. A self-study module has been sent to all birth hospitals, and pediatric health care providers in Ohio.

Performance Measure 9: Percentage of mothers who breast-feed their infants at hospital discharge.

- The annual performance objective (target) for FY99 was 53.0% of births
- The annual performance indicator (actual) for FY98 was 56.1% of births.

The annual performance objective was met. The DFCHS programs' support of breastfeeding women during hospital stays and early post-discharge period is an important factor in this success.

In 1998, according to Ross Laboratories, 56.1% of all mothers of infants in Ohio were breast-feeding at hospital discharge (Ross Labs Mother's Survey). For WIC mothers the rate was 41.7% in 1998 and the rate for CFHS clients was 19.8% (MATCHr).

Local WIC projects observed World Breastfeeding Week (WBW)) and Breastfeeding Promotion Month with a variety of educational activities in their clinics and in the communities.

State WIC office provided a one-day Back-to-Basics Breastfeeding Management Seminar training to 250 local agency staff during August 1999. Attendees included local prenatal program staff, Welcome Home Program nurses, and WIC Program health professionals and support staff.

Ohio has approximately 30 local breastfeeding task forces functioning at various levels of activity. At the local level, educational seminars were sponsored by: the Ohio Valley Breastfeeding Coalition, the Holmes County Breastfeeding Coalition, the Ashtabula County Breastfeeding Coalition, the Tri-state Breastfeeding Coalition, and the Hancock County Breastfeeding Coalition.

WBW information packets were mailed to 80 CFHS projects.

ODH Breastfeeding Policy was distributed to 62 CFHS Perinatal Clinics.

Performance Measure 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

- The annual performance objective (target) for FY99 was 8.8% of births.
- The annual performance indicator (actual) for CY98 was 16.1% of births.

The annual performance objective for FY99 was met. Ohio's current law calls for a paper screening for risk, rather than universal hearing screening, therefore the current numbers are low. ODH plans to implement a combined newborn data system in Ohio's birth hospitals in 2000; this data system will provide the Department with information necessary for a comparison of the number of newborns whose hearing is screened and subsequently tested before hospital discharge with the number of births in each hospital.

Hospitals with newborn nurseries were surveyed to determine which were providing hearing screenings for newborns with risk factors for hearing loss. Preliminary results show that 110 hospitals responded, with 45 (41%) reporting that hearing screening is provided for at-risk newborns in the hospital. Seven hospitals (6%) report having universal newborn hearing screening programs.

All newborns found to be high risk for hearing loss were either provided further auditory testing at the birth hospital or referred to community testing sites. Since not all birth hospitals are equipped to conduct auditory testing such as otoacoustic emissions or brainstem evoked response testing, it is estimated that 16.1% of all infants born in hospitals received an electrophysiological screening for hearing impairment.

Children

Performance Measure 5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

- The annual performance objective (target) for FY99 was 82% of 2 year olds for the 4:3:1:3 series.
- The annual performance indicator (actual) for FY99 was 68.6% of 2 year olds for the 4:3:1:3 series.

The target was not met. Data provided represents the results of a statewide birth certificate-based survey conducted by the ODH, Division of Prevention, Immunization Program. The development of a state immunization registry tracking system is in progress.

CFHS clinics had an immunization rate through the age of two of 81% (4:3:1 series), while the 1998 Ohio rate was 77.2%. The current data collection system for the BCFHS program does not collect Hemophilus and Hepatitis B immunizations. CFHS clinics are monitored for missed immunization opportunities and technical assistance is provided to project staff in clinics with compliance rates less than 80 percent. As a result, BCFHS staff provided technical assistance for two CFHS projects.

WIC projects improved the immunization status of children by increasing the number of appropriate referrals for immunizations from 37% to 41%. WIC records showed that 52% of children had complete immunizations for their age.

BCMH provided immunization compliance data for CSHCN who are cared for in tertiary care centers and included immunization status as part of the individual service plans. Specific needs related to diagnoses are taken into consideration along with the appropriate coordination with the child's physician to individualize the immunization schedules.

Immunization compliance is monitored for children who receive public health visits by BCMH. All services performed by the local public health nurse are recorded in the child's record and on the BCMH PHN Services Report Form which includes a specific area to record compliance and the actions taken if the immunizations are not up to date. All reports are reviewed by BCMH nursing consultant staff.

HMG promoted the Ohio's Infant Immunization Public Awareness campaign through its private-public partnership. HMG along with the Kroger Company placed radio and print ads in central Ohio about the importance of immunizations.

Performance Measure 6: The birth rate (per 1,000) for teenagers aged 15 through 17 years.

- The annual performance objective (target) for FY99 was 27.8 per 1,000 females 15-17.
- The annual performance indicator (actual) for CY98 was 26.6 per 1,000 females 15-17.

The annual objective was met. DFCHS provided health services to women and consultation/technical assistance to agencies involved in teen pregnancy issues and programs. DFCHS ensures both availability of services and standards of care for women of childbearing age, and provides opportunities to incorporate preventive and abstinence only education materials and consultation.

The number of live births for females ages l5-17 decreased from 6,891 in l997 to 6,476 in l998. The birth rate for this same group decreased from 28.4 in l997 to 26.6 in l998.

Title X and Title V funded family planning agencies in 84 counties provided services to 13,375 clients (both males and females) ages 15 to 17. Agencies that received family planning funds included local health departments, community action agencies, community health centers, hospitals, and Planned Parenthood agencies.

DFCHS staff provided consultation and technical assistance regarding pregnancy prevention to the Franklin County Prevention Institute; the Lucas County Community Prevention Partnership; Ohio's Parents for Drug Free Youth; Healthy Youth-Healthy Community/Licking County; city/county health departments; social service agencies; and hospitals providing adolescent health clinics.

The Adolescent Health Advisory Committee held one general exploratory meeting, but definitive progress on resiliency/protective factors for community initiatives has not progressed. The Ohio Legislature has been invited to participate in developing an Adolescent Health Plan for Ohio.

33 agencies received Abstinence Only Education grants. A variety of programs were provided through community-based agencies, schools, health departments, hospitals, county departments of human services, and Family and Children First Councils. Technical assistance was also provided to these agencies.

Performance Measure 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

- The annual performance objective (target) for FY99 was 45% of Ohio 3rd graders.
- The annual performance indicator (annual) for FY99 was 34% of Ohio 3rd graders.

The target of 45 percent of third graders having dental sealants was not met. However, in the sealant schools (which target the highest risk students), 55 percent of the 8 year old high-risk students (those on free/reduced school meals) have dental sealants. This indicates that the students who need sealants most (those from low-income families) are the ones receiving them. Only 23 percent of the children enrolled in Medicaid had a claim for a dental exam in FFY97. Therefore, most Medicaid-eligible children are not going to the dentist and have a greater chance of getting sealants at school than at the dentists' office.

No communities were identified as interested in developing or expanding dental sealant programs.

A statewide open mouth screening survey was conducted in 336 elementary schools in Ohio, which found that 34% of Ohio's third grade students have a dental sealant on one or more permanent molar teeth.

Fifteen local dental sealant programs were funded and served over 26,000 students in 30 counties. The programs received technical assistance through site visits.

The Director of Health convened a Task Force on Access to Dental Services to develop a state level strategic plan that will improve access to dental care for vulnerable Ohioans. In addition, two advisory committees, one working on community level infrastructure and another working on improving access to oral health services for high risk children through school programs were convened.

Performance Measure 8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

- The annual performance objective (target) for FY99 was 4.0 per 100,000 Ohio children 1-14 years.
- The annual performance indicator (actual) for CY98 was 4.7 per 100,000 Ohio children 1-14 years.

The annual performance objective was not met. Continued efforts to implement program actions will be maintained. There is a new level of collaboration at state level between Division of Prevention's (DOP) injury prevention coordinator and the Ohio Dept. of Public Safety's Emergency Medical Services for Children (EMSC).

In CY98 the motor vehicle death rate for children aged one to fourteen years was 4.7 deaths per 100,000 population as compared to 4.2 per 100,000 in 1997.

In collaboration with DOP's injury prevention coordinator, information regarding infant safety seats was distributed.

Telephone technical assistance was provided to several counties. A list of grantees that are performing child passenger safety and injury prevention activities was developed and will be utilized in targeting technical assistance**.**

The HMG Helpline provided 430 child safety referrals, 1,256 Individual Child Safety Information Packets, 246 transfer to ODH's Safety Program, and over 6,000 Car safety Belt Brochures order in bulk quantities.

State Negotiated Performance Measure 9: The percentage of all children screened for elevated blood lead levels as defined by the Centers for Disease Control and Prevention.

- The annual performance objective (target) for FY99 was 5.5% of children screened for elevated blood lead levels.
- The annual performance indicator (actual) for FY99 was 5.7% of children screened for elevated blood lead levels.

The annual performance objective for FY99 was met. DFCHS's primary impact on childhood lead poisoning prevention in Ohio is through the education resources provided by the MCH Block Grant funded Regional Resource Centers (RRC) and through the direct blood lead screening provided by the CFHS well child clinics. The program maintained an effective statewide blood level testing database through the use of STELLAR with the following findings:

137,159 blood lead lab results were processed
124,546 children were screened
7,054 children with elevated blood levels $\geq$10 ug/dL

Four RRCs were funded in Cincinnati, Cleveland, Mahoning County and Seneca County. Community Profiles were developed for each county.

Development continued on the peer-based curriculum for health care providers called PLANET (Pediatric Lead Assessment Network).

The OSU Rural Lead Education Five-Year Project has been undertaken to assess the various degrees of intervention levels in three rural counties. The OSU research project goal is that knowledge generated from the study will help build empirical guidelines for interventions by public health consultants and by local public health nurses planning rural primary and secondary community prevention efforts.

Community Collaborative groups have been formed and continue to meet quarterly in Portsmouth and Steubenville. These projects, while funded by the CDC, draw heavily upon the support provided by the MCH Block Grant RRCs for technical and consultative assistance.

Advisory Committee and Project Director's Meetings were held quarterly as scheduled.

Children with Special Health Care Needs

State Negotiated Performance Measure 4: The percent of resident newborns who have confirmed PKU, hypothyroidism, galactosemia or a hemoglobinopathy who are referred to a specialty physician for appropriate treatment in the reporting year.

- The annual performance objective (target) for FY99 was 98% referred to specialist.
- The annual performance indicator (actual) for FY98 was 100% referred to specialist.

The annual performance objective for FY99 was met and all newborns with a confirmed diagnosis are under a physician's care.

DFCHS implemented a broad-based education program to all providers during FY 99. A self-study module (for hospital staff and physicians) was developed and implemented last year and has continued in this fiscal year. In addition, all hospitals and birthing centers in Ohio received a site visit and inservice training from ODH Laboratory NBS staff.

Aggregate reports with referral, diagnostic and treatment data were submitted to the ODH Newborn Screening Program by the Regional Comprehensive Sickle Cell Centers in Ohio.

Infrastructure Building

Pregnant Women, Mothers and Infants

Performance Measure 15: Percent of very low birth weight live births.

- The annual performance objective (target) for FY99 was 1.40% of live births.
- The annual performance indicator (actual) for CY98 was 1.50% of live births.

The annual performance objective was not met. DFCHS along with its partners will continue to provide an intensive effort to meet this objective.

A total of 75 CFHS projects in 61 counties provided 106,757 perinatal visits to 18,801 unduplicated clients. In preparation for FY2000 competitive grant application 75 CFHS perinatal projects received technical assistance by phone with information about looking at data and assessing their health needs.

A total of 18 CFHS projects in 18 counties provided 38,737 family planning visits 15,371 unduplicated clients.

OIMRI grants were awarded in 10 counties (Clark, Cuyahoga, Franklin, Lorain, Lucas, Mahoning, Montgomery, Stark, Summit, and Wood) to reach out to high risk, low income un/under insured pregnant women within specific target areas by census tracks and neighborhoods. Nine hundred women were served in this program.

DFCHS staff served on a number of committees/task forces/boards to provide technical assistance on MCH issues (e.g., Cleveland Healthy Family/Healthy Start; Franklin County Leadership Council for Infant Mortality Reduction).

The Pregnancy Risk Assessment Monitoring System (PRAMS) and a statewide Prenatal Smoking Cessation Program were implemented.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

- The annual performance objective (target) for FY99 was 65% of infants less than 1500 grams.
- The annual performance indicator (actual) for CY98 was 59.3% of infants less than 1500 grams.

The annual performance objective for FY99 was not met. In CY 97 the performance indicator was 60.6%; however, progress has been made over the years and continued efforts are expected in the future.

62 CFHS clinics utilized the Prenatal Risk Assessment (PRA) to assess the potential risk of pregnant clients (verified by survey and site visits).

Seven Regional Perinatal Teams were funded in Ohio (University Hospitals of Cleveland; MetroHealth in Cleveland; OSU Research Foundation; Children's Hospital in Cincinnati; Toledo Hospital; Children's Medical Center in Dayton; and Akron's Children's Hospital) and provided 851 educational programs and 210 technical assistance visits.

Maternity Licensure Program consultants conducted quality assurance visits to 140 hospitals, 5 maternity homes, and 2 birthing centers.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

- The annual performance objective (target) for FY99 was 86% of live births with reported care in first trimester.
- The annual performance indicator (actual) for CY98 was 85.1% of live birth births with reported care in first trimester.

The annual objective was not met. DFCHS along with its partners will continue an intensive effort toward this objective and will commit the same level of resources.

To reinforce and advocate for the importance of first trimester care, the BCFHS Chief attended three ACOG meetings in which early and adequate prenatal care, HIV and prenatal smoking were discussed.

Seven Regional Perinatal Teams were funded (University Hospitals of Cleveland; MetroHealth in Cleveland; OSU Research Foundation, Children's Hospital in Cincinnati; Toledo Hospital; Children's Medical Center in Dayton; and Akron's Children's Hospital) and provided technical assistance to other local hospitals.

75 CFHS projects in 61 counties provided 106,757 perinatal visits to 18,801 unduplicated clients. 67.4% of the women entered prenatal care in the first trimester.

Help Me Grow (HMG) Helpline distributed 294,282 Wellness Guides to publicly funded Clinics (29%); Physicians (20%); Hospitals (19%); Pharmacies (6%); Consumers (3%); and other requests (23%).

HMG distributed outreach materials to 620,000 Ohio Works First recipients and provided radio airtime for public service announcements (PSAs) promoting early and continuous prenatal care

State Negotiated Performance Measure 10: Implementation of pregnancy risk assessment monitoring system (PRAMS) in Ohio.

- The annual performance objective (target) for FY99 as a process measure was completing Steps 1 and 2.
- The annual performance indicator (actual) for FY99 was met.

Ohio PRAMS, totally funded by Title V, is a collaborative effort among many internal (BCFHS, BHSIOS and HMG within DFCHS, OMIS, Vital Statistics, Division of Prevention BRFSS Interviewers) and external agencies. Ohio PRAMS data are expected to be available for dissemination as the Ohio PRAMS Databook in May 2001.

The Data Coordinator and Program Coordinator were hired. Both coordinators and other PRAMS team members participated in on site CDC training sessions in January and April 1999 on PRAMS Methodology and Implementation.

A PRAMS Steering Committee has been developed with the following members: Children's Defense Fund; Ohio Department of Alcohol and Drug Addiction Services; Ohio Department of Human Services; Planned Parenthood; Ohio State University; Help Me Grow; Columbus Health Department; Ohio Public Health Association; and various ODH bureaus. Meetings have been held quarterly to discuss PRAMS implementation, data analysis, and communication.

The Ohio PRAMS team submitted and received approval by CDC for the protocol. The protocol describes in detail the methodology of the Ohio PRAMS project.

The Ohio survey questionnaire was developed which included state specific questions; the incentive and reward were selected; the phone phase interviewers were trained and have been interviewing; and Institutional Review Board (IRB) approval was obtained.

The Ohio PRAMS project began sampling and sent out the first batch of surveys in April 1999. The project has a sampling methodology that stratifies by race (black & non-black) and birth weight (low and normal birth weight).

The Ohio PRAMS team, in partnership with the Steering Committee, developed a Data Analysis Plan and a Communication Plan. The PRAMS team is working with the CDC representatives on PRAMS Operations Evaluation.

Children

Performance Measure 12: Percent of children without health insurance.

- The annual performance objective (target) for FY 99 was 8.5% of Ohio children under 18 years.
- The annual performance indicator (actual) for FY98 was 9.8% of Ohio children under 18 years.

The annual objective for FY99 was not met. Even with the expansion of Medicaid/Healthy Start, there are many factors not directly related to the uninsured rate that affect the annual performance objectives. DFCHS programs will continue to promote outreach and enrollment on Medicaid/Healthy Start.

The 1998 uninsured estimate for children 0-17 years old is 9.8%. The estimate is from the Ohio Family Health Survey (OFHS), which was conducted from January through August 1998. The OFHS estimate has a higher degree of accuracy than the Current Population Survey (CPS) because of a substantially larger sample size and weighting of the sample size by age, gender, education and race at the state level. Ohio's five-year trend has been inconclusive according to the CPS. While there has been year-to-year fluctuations in the uninsured rates, the difference from 1994 to 1999 was not statistically significant.

Through site visits, surveys, input from providers and consumers, factors identified that contribute to potential Medicaid eligible families with children not pursing Medicaid eligibility include: families mistakenly believe that Healthy Start counts against their lifetime eligibility for welfare benefits; application is burdensome; stigma associated with Medicaid; application process is not user friendly nor culturally sensitive; and families may not be aware of the program.

Outreach activities for access to health care as developed in *A Plan for Medicaid/Child Health Insurance Plan for Children* included: outreach information through training and workshops to over 150 school nurses and more than 300 project directors of CFHS, WIC and EI programs.

HMG promoted Healthy Start to consumers by distributing nearly 300,000 *Help Me Grow: A Wellness Guide for Mother's-To-Be and Their Babies and Health Diary.* This magazine contained a full-page ad for the Healthy Start program.

Every woman, infant, and child continues to be screened at every initial and subsequent WIC certification to determine if a referral needs to be made to Medicaid/CHIP. There are over one-half million screenings per year in the 245 WIC clinics.

State WIC provided mailings labels to ODHS so that the Medicaid consumer video *A Healthier Ohio* was mailed to each of the 245 WIC clinics to show in WIC waiting areas.

Through OPTIONS, the statewide dental access program, 668 individuals were identified as potentially eligible for Medicaid and referred to the Medicaid helpline to enroll in the program.

When BCMH identifies a family that is potentially eligible for Medicaid, the family is referred to the local department of human services to apply as a condition of acceptance onto the BCMH treatment program.

DFCHS staff participated in workgroups with ODHS, and OFCF to promote access to Healthy Start. These workgroups included: revising the Combined Programs Application, participating on the ODH outreach advisory committee, and bi-monthly meetings to discuss issues regarding eligibility, quality assurance for CSHCN enrolled in Medicaid and policy issues that impact on CSHCN.

Other collaborative efforts included participation in the state/local coalition of the Ohio Minority Health Commission's Covering Kids Initiative funded by the Robert Wood Johnson Foundation.

BOHS worked collaboratively with the ODHS on a joint report about access to oral health care for Ohioans. Both agencies are working to compile data for the report. ODHS is reporting Medicaid utilization data and the Bureau is preparing data from the statewide oral health survey, access surveys sent to Ohio dentists, high-risk families and dental safety net programs. Information on existing resources for dental care and barriers to receiving care will be included in the report.

Primary Care and Rural Health collected uninsured patient encounters on a quarterly basis from 70 FQHCs throughout Ohio.

According to the Ohio Family Health Survey, one-third (33%) of children to age 18 in Ohio do not have any form of dental insurance.

Performance Measure 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

- The annual performance objective (target) for FY99 was 92.6% of potentially eligible children.
- The annual performance indicator (actual) for FY98 was 79.4% of potentially eligible children.

The annual performance measure was not met. This data for the potentially Medicaid eligible children are not readily available and the estimates are based on the Ohio Family Health Survey and the Current Population Survey. DFCHS in partnership with Ohio Department of Human Services (ODHS) has taken a leadership role by informing families with children about Medicaid/Healthy Start.

According to ODHS, after 22 months of implementation of Healthy Start/CHIP the program is serving over 64,000 children or 25% of the potentially eligible population. This includes about 59.4% of the uninsured and 9.9% of the insured potentially eligible.

For FFY 97, according to HCFA-416 report, HEALTHCHEK (Ohio's EPSDT program) visits were conducted for 65% (546,560 of 834,466) of the children enrolled in Medicaid.

A total of 48,546 children, ages 0-11, who received CFHS services were potentially Medicaid eligible. Analysis of the MATCHr data reflects that 65.3% of the children who received CFHS services had services paid by Medicaid/Healthy Start.

For FFY 97, according to HCFA-416 report, dental assessments were conducted for only 23% (190,556 of 834,466) of the children enrolled in Medicaid.

Collaborative efforts and activities to promote outreach as developed in DFCHS' *A Plan for Medicaid/Child Health Insurance Eligibility Outreach* are described in the activities for performance measure 12.

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths 15-19.

- The annual performance objective (target) for FY99 was 5.8 per 100,000 youths 15-19 years.
- The annual performance indicator (actual) for CY98 was 8.7 per 100,000 youths 15-19 years.

The annual objective for FY99 was not met. ODH was able to provide limited consultation due to limited resources hampering the establishment of extensive intervention techniques.

BCHSSD staff participated in the Ohio Department of Mental Health's school-based program, "Red Flags" and sponsored two satellite video presentations focusing on community initiatives to promote positive mental health while identifying environmental, familial, and social indicators demonstrating increased risk for adolescent suicide.

BCHSSD staff worked with ODE's Youth Risk Behavior Survey (YRBS) to include access to health care issues in Ohio's l999 YRBS. Statewide adolescent health focus groups were conducted to identify barriers for access to health care, including mental health services.

BCHSSD staff provided consultation to local community health and social service agencies on the availability, use, and need for adolescent risk assessment tools/inventories to determine those adolescents most at risk for attempting/committing suicide.

BCHSSD staff provided consultation to local health departments determined to have rates of adolescent suicides above the state and national average. Consultations/collaborations occurred with communities engaged in healthy youth-healthy community initiatives, local/health and mental health agencies, hospital-based adolescent clinics, and school-based health initiatives. As part of the new Public Health Nurse Course taught by the Ohio Department of Health, a session was spent with new public health nurses discussing adolescent risk behaviors, resiliency and asset building theories.

Children with Special Health Care Needs

Performance Measure 11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.

- The annual performance objective (target) for FY99 was 80.7% of children on the BCMH Program.
- The annual performance indicator (actual) for FY99 was 76.2% of children on the BCMH Program.

The annual performance indicator was not met. BCMH refers all potentially Medicaid eligible families and individuals to their county Department of Human Services for Medicaid eligibility determination. Even though BCMH assists families in applying for Medicaid, some families do not follow through with the application process. Also, BCMH serves a significant number of Amish families who do not have insurance and will not accept Medicaid.

BCMH nurses assisted potentially eligible Medicaid families in understanding the requirements and completing the paperwork necessary to apply for Medicaid.

BCMH paid private insurance premiums for 34 recipients. BCMH spent approximately $65,000 for the premiums, which saved over $550,000 in treatment expenditures that otherwise would have been paid by BCMH.

Performance Measure 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

- The annual performance objective (target) for FY99 was 18 points of 18 on a scale.
- The annual performance indicator (actual) for FY99 was 18 points of 18 on a scale.

The annual performance objective was met. BCMH has extensive interaction with families through educational updates held in conjunction with a number of other state agencies (Education, Human Services, Mental Retardation/Developmental Disabilities, etc.) as well as the bureau's own Parent Advisory Committee and ad hoc meetings with concerned parents.

BCMH employs a full time parent consultant who assures family participation and policy development in the program.

The Parent Advisory Committee met four times.

Parents were involved in the following committees: Autism Guidelines Development; Children with Disabilities Committee of the Ohio Developmental Disabilities Planning Council; Access to Dental Services Task Force; Committee on Outcomes for CSHCN; and Medical/Health Home Survey Development.

Parents were involved in training and seminars that included: updates for families, public health nurses, and managed care organizations; services coordination for CSHCN with MCOs; and production of a training video concerning folic acid.

State Negotiated Performance Measure 3: Progress planned and accomplished in the development of a program to conduct birth defect surveillance.

- The annual performance objective (target) for FY99 as a process measure was completing Step 1.
- The annual performance indicator (actual) for FY99 was met.

A study was completed to evaluate existing data sources on a small scale and for a birth defect likely to be recognized prior to hospital discharge (neural tube defects). This activity was not conceived to constitute a surveillance system, but rather to be a one-time attempt to evaluate existing data sources to determine their usefulness in forming the basis of a Birth Defect Information System (BDIS) in Ohio. Data sources included in this study were birth certificates, Bureau for Children with Medical Handicaps (BCMH) records, and BCMH recognized Myelomeningocele Teams throughout Ohio. A key finding of the study was that existing data sources were not sufficient for conducting birth defects surveillance in Ohio.

A report was submitted to the Director of the Ohio Department Health detailing these activities and making recommendations.

Progress on Outcome Measures

Outcome measure 1: The infant mortality rate per 1,000 live births

- The annual performance objective (target) for FY99 was 7.2 per 1,000 live births.
- The annual performance indicator (actual) for CY98 was 8.0 per 1,000 live births.

The annual performance objective was not met. DFCHS will continue to implement programs and interventions to meet this target.

The Ohio infant mortality rate in 1998 was 8.0 infant deaths per 1,000 live births. The infant mortality rate for blacks was 14.2 per 1,000 live births; 6.9 per 1,000 live births for whites; and 5.0 per 1,000 live births for others.

The Fresh Start Smoking Cessation Program was implemented and 18 technical assistance visits were made to agencies starting the program.

BCFHS provided perinatal services in 61 counties to 18,801 women in 106,757 visits; 67.4% of the women entered prenatal care in the first trimester.

Family planning services were provided to 88,022 clients in 188,761 visits.

CFHS child health clinics provided comprehensive child health services to 10,948 infants and 48,623 children ages one to 22.

OIMRI projects in 10 counties served 900 pregnant women, who are high-risk, low income and uninsured or underinsured in target areas where the Infant Mortality Rate is 9.0 or higher per 1,000 live births or where the Low Birth Weights is 80 or higher per 1,000 live births.

The HMG Program provided infant and child safety information, including distributing 1,256 child safety information kits and over 6,000 car safety belt brochures.

Outcome measure 2: The ratio of the black infant mortality rate to the white infant mortality rate

- The annual performance objective (target) for FY99 was a ratio of 2:2.
- The annual performance indicator (actual) for CY98 was a ratio of 2:1.

The annual performance objective was not met. DFCHS is committed to meeting this objective and will continue focusing efforts on reducing disparities in health indicators.

The 1998 infant mortality rate for blacks was 14.2 per 1,000 live births compared to white infant mortality rate of 6.9 per 1,000 live births for a ratio of 2.1.

OIMRI provided technical assistance to funded projects to enhance the development and implementation of culturally appropriate outreach programs that identified and assisted high risk, low income pregnant women to obtain first trimester prenatal care, case management/care coordination and to provide home visits through the baby's first year of life. OIMRI served 900 women and linked them to appropriate health care and social services agencies, including WIC

Refer to the activities in Outcome Measure 1 that target this outcome.

Outcome measure 3: The neonatal mortality rate per 1,000 live births

- The annual performance objective (target) for FY 99 was 5.1 per 1,000 live births.
- The annual performance indicator (actual) for CY98 was 5.3 per 1,000 live births.

The annual performance objective was not met. DFCHS will continue to implement programs and interventions to meet this target.

In 1998, the neonatal mortality rate was 5.3 per 1,000 live births as compared to 5.2 per 1,000 live births in 1997. The rate for whites was 4.7 neonatal deaths per 1,000 for whites compared to a black neonatal mortality rate of 8.9 per 1,000 live births. This ratio of black to white neonatal deaths per 1,000 live births was 1.9.

Refer to the activities referenced in Outcome Measure 1 that target this outcome.

Outcome measure 4: The postneonatal mortality rate per 1,000 live births

- The annual performance objective (target) for FY99 was 2.5 per 1,000 live births.
- The annual performance indicator (actual) for CY98 was 2.6 per 1,000 live births.

The annual performance objective was not met. DFCHS will continue to implement programs and interventions to meet this target.

The 1998 Ohio postneonatal mortality rate was 2.6 per 1,000 live births. The postneonatal mortality rate for whites was 2.2 per 1,000 live births compared to a black Postneonatal Mortality Rate of 5.3 for a black/white ratio rate of 2.4.

A grant was provided to the SID Network of Ohio for parent support group education materials and to facilitate a statewide conference attended by over 150 parents and health care professionals.

The SID Network and the Coroner's Association reported that 70% of the coroners are using the correct reporting forms and protocols.

ODH cooperated with the SID Network of Ohio to support the *Back to Sleep* campaign.

Outcome measure 5: The perinatal mortality rate per 1,000 live births

- The annual performance objective (target) for FY99 was 14.6 live births plus fetal deaths.
- The annual performance indicator (actual) for CY98 was 12.0 live births plus fetal deaths.

The annual performance objective was met. DFCHS will continue to maintain a concerted effort to continue improving this outcome measure.

BCFHS funded family planning and prenatal services as described in Outcome Measure 1.

Updates on current prenatal issues and information were provided to local CFHS, EI and WIC professionals through the promotion of alcohol and other birth defects awareness materials.

Seven regional perinatal centers were funded and provided 851 educational programs and 210 technical assistance activities to health care professionals.

HMG Program's Wellness Guides were distributed and served as a tool to remind pregnant women of WIC and other health care services.

Outcome measure 6: The child death rate per 100,000 children aged 1-14

- The annual performance objective (target) for FY99 was 25.0 per 100,000.
- The annual performance indicator (actual) for CY98 was 23.1 per 100,000.

The annual performance objective was met.

BCFHS provided child health services, including education and counseling services to 48,623 children ages one to 21.

BCHSSD funded one school-based health center that provides urgent care at 2 high-risk inner city schools.

BCHSSD staff presented safety information to over 140 school nurses throughout Ohio at the annual New School Nurse Orientation and developed technical assistance trainings in adolescence for health care providers.

BCHSSD staff provided consultation to local community health and social service agencies on the availability, use, and need for adolescent risk assessment tools/inventories to determine those adolescents most at risk for attempting/committing suicide.

State outcome measure 1: The rate of neural tube defects per 10,000 pregnancy outcomes

- The annual performance objective for FY99 (target) was 4.3 per 10,000 pregnancy outcomes.
- The annual performance indicator for CY98 (actual) was 3.7 per 10,000 pregnancy outcomes.

The annual performance measure was met.

A study was completed to evaluate existing data sources on a small scale and for a birth defect likely to be recognized prior to hospital discharge (neural tube defects only). This activity was not conceived to constitute a surveillance system, but rather to be a one-time attempt to evaluate existing data sources to determine their usefulness in forming the basis of a Birth Defect Information System (BDIS) in Ohio. Data sources included in this study were birth certificates, Bureau for Children with Medical Handicaps (BCMH) records, and BCMH recognized Myelomeningocele Teams throughout the state.

DFCHS conducted statewide folic acid (FA) education activities to increase awareness for Ohioans about the use of folic acid in the reduction of neural tube defects. ODH established a FA Work Group that designed and is implementing a FA plan to promote knowledge about FA (e.g., televised as a subject on ODH's "PH1" television program shown throughout Ohio's cable TV systems), and to promote networking regarding FA activities in the state. Other activities included publishing and distributing statewide a position paper on folic acid and the reduction of NTDs, and enhancing FA education throughout Ohio through the Regional Comprehensive Genetics Program.

3.1. Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Overview : Ohio took a thorough, multifaceted approach to assessing and prioritizing the health issues of the State's maternal and child population. The Division of Family and Community Health Services (DFCHS) avoided the common mistake of limiting information to available quantitative data in preparing a needs assessment. DFCHS also assessed the perceived needs of consumers and other key informants (via qualitative information). Ohio went to great lengths to gather information necessary to provide a balanced and comprehensive needs assessment.

DFCHS formed an internal committee to plan and guide the needs assessment process. This committee, referred to as the Needs Asssessment Team, consists of ODH staff from within the Division and from other areas within the agency not related to maternal and child health (MCH) programs. The needs assessment was an inclusive process that also involved the following parties:

- Members of the MCH Council, an outside advisory committee

- Interested agencies and organizations (provided comments on the Data Collection Plan)
- Ohio families, legislators, local health commissioners, members of the Governor's Cabinet, and key members of the Governor's Office (provided information via surveys and interviews)

See Participants in the Needs Assessment Process in the Appendix.

Model for the Needs Assessment: The Ohio needs assessment was based on the community needs assessment model developed by ODH through collaboration with local health departments. That process was documented in *Ohio's Public Health Plan*, released in 1997. The 9-step process is illustrated as a community needs assessment "wheel." *See the Appendix.* Steps 1 through 6 represent the needs assessment phase, steps 7 through 8 are the planning phase, and step 9 is evaluation. The Ohio plan recognizes the need to do analytical studies to ascertain root causes of problems and includes a data analysis agenda to be carried out in the years between the needs assessments required for the MCH Block Grant. The data analysis/research agenda is outlined in section 3.2.2.

Data Collection Methods The Needs Assessment Team drafted a Data Collection Plan using data required to measure the MCH Block Grant performance and outcome measures, and the health status indicators that were being developed by the federal MCH Bureau. Care was taken to add items that were important to assessing the needs of the population, even if the items were not a reporting requirement of the MCH Block Grant (i.e., performance measures, health status indicators). During this process, the Team added a number of qualitative items and planned a variety of primary data collection efforts (e.g., focus groups, surveys). A draft Data Collection Plan was mailed to 60 non-ODH people for comment. Based on a discussion of desirable characteristics, the Team reduced the list of data items to a manageable size. *See the final version of the Data Collection Plan in the Appendix.* Staff from DFCHS formed workgroups to assemble data for the following areas: demographics; maternal and infant (women of childbearing age and infants); children and adolescents; and children with special health care needs (CSHCN).

Sources of Data: Secondary data were collected from sources such as the U.S. Bureau of the Census, the U.S. Department of Agriculture, the Ohio Department of Education, the Ohio Department of Human Services (ODHS), and ODH Vital Statistics**. *See the Data Collection Plan in the Appendix for a complete list of the data collected and the sources.***

In addition to collecting secondary data, primary data (quantitative and qualitative) were collected through surveys and interviews conducted by ODH and by contractual parties. These surveys and interviews are listed below. ***See Perceived Needs Information in the Appendix for a more detailed description of some of the surveys and interviews.***

- ***Number of CSHCN:*** Under a contract funded by Statewide Systems Development Initiative (SSDI) dollars, The Ohio State University (OSU) generated synthetic estimates of CSHCN, by condition.
- *Oral Health Survey* Under the same contract as above, OSU analyzed data from the Oral Health Survey (screening of more than 21,000 children in grades 1 through 3 in all 88 counties).

- *Medical Home Survey of CSHCN and Early Intervention Clients* ODH conducted a mail survey of a sample of CSHCN served by the Bureau for Children with Medical Handicaps (BCMH) and the Bureau of Early Intervention Services (BEIS).
- *Ohio Family Health Survey* ODH contracted with the Gallup Organization to conduct telephone surveys of 16,261 households to obtain opinions on unmet health care needs.
- *Focus Groups* DFCHS collaborated with the ODH Center for Public Health Data and Statistics to schedule 43 focus groups as follow-up to the Family Health Survey. The University of Dayton Center for Business and Economic Research conducted the meetings and summarized the results. Participants were parents of CSHCN, parents of children to age 14, adolescents (including Black), adults with disabilities, working people who were uninsured, local health commissioners, and employers.
- *Household Survey* Questions were purchased on the Ohio Poll, a household telephone survey of 870 adults conducted by the University of Cincinnati. Respondents were questioned about health issues and problems facing Ohioans.
- *Key Policy Maker Interviews* Face-to-face interviews of local health commissioners, legislators, members of the Governor's Cabinet, and key staff members in the Governor's office were conducted through a contract with Lorz Communications, Inc. Participants discussed unmet health care needs for their constituents/communities.
- *Community Health Assessments* The Bureau of Child and Family Health Services (BCFHS) analyzed needs assessments conducted by 80 local Child and Family Health Services (CFHS) projects.

Prioritization Methods Through extensive meetings and reviews, the needs assessment team developed and refined an instrument for prioritizing health issues. The instrument included the quantitative and qualitative data collected. *See Prioritization Instruments and Criteria (weighted scoring system) in the Appendix.* The data outlined in the Data Collection Plan were synthesized into a concise format for a formal two-step prioritization process:

Phase 1 Separate one-day workshops were conducted to prioritize health issues for each of the following groups: maternal and infant, children and adolescents, and CSHCN. Attendees were members of the MCH Council, DFCHS staff, and other ODH staff. Individually, participants scored the health issues by combining the information in the prioritization instrument with their professional judgment. Then, the participants as a group reviewed the rankings and refined them per consensus.

Phase 2 A one-day workshop was attended by the State MCH Director and her executive staff of Bureau Chiefs, and the Assistant Director for ODH. This group undertook a voting process to create a single list of MCH priorities from the priorities that resulted from the three Phase 1 workshops. In addition, 13 potential state performance measures were identified for future consideration by the MCH Council. In a subsequent meeting, the Council selected the 10 state performance measures that are listed elsewhere in this application.

The results of the prioritization process are reported in Section 3.2.1.

Once the priority health issues were identified, the DFCHS workgroups undertook a process to identify the need for services at different levels of the pyramid in order to address these needs. The results of this process are reported in Sections 3.1.2.2/3.1.2.3.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

This section summarizes the qualitative and quantitative information that was presented to the stakeholders who prioritized health issues for the MCH population. This information pertains to health status issues. (See Sections 3.1.2.2 through 3.1.2.5 for data related to health services and systems.) The quantitative information was assembled based on the Data Collection Plan. Information on disparities is provided if it was documented. Racial, age, and gender disparities were not reported if disparities were not observed, the numbers were too small to interpret, or the information was not collected. The qualitative information is from surveys, interviews, and focus groups. (See B.4, B.5, C.12, and C.13 in this section.)

A. Demographics

A.1 Geographic Description

Ohio has a land area of 40,953 square miles and is divided into 88 counties. Because Ohio has no geographical barriers, its accessibility has been perhaps the key factor in its growth. A well-developed interstate highway system interconnects the state: interstate highways 70, 76, 80, and 90 run east and west, and interstate highways 71, 75, and 77 run north and south.

A.2 Population

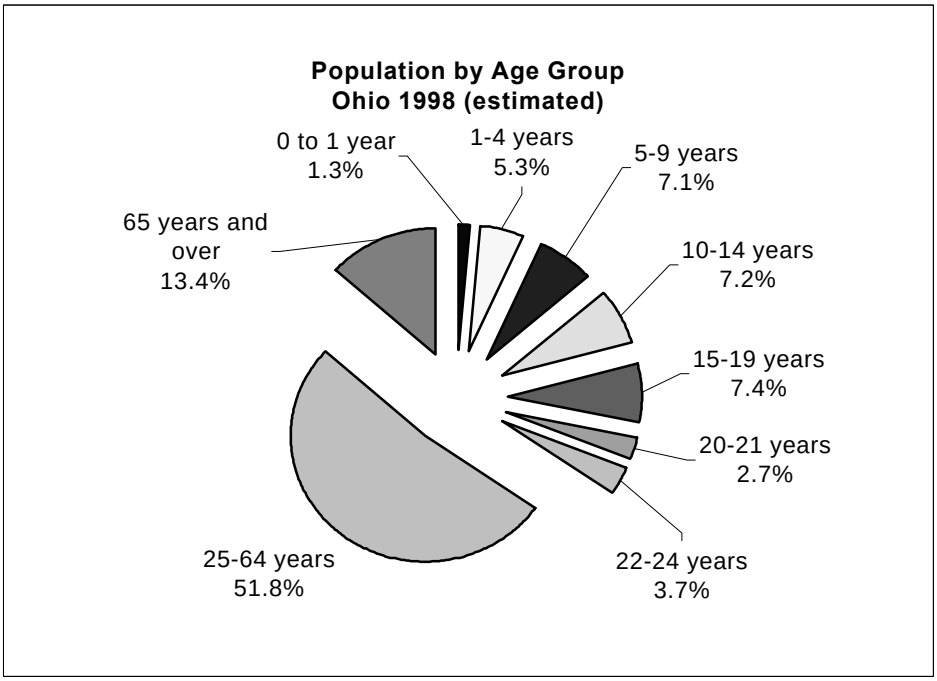
Overall The 1998 estimated population was 11,209,493, giving a population density of 273.7 people per square mile. Ohio ranks as the seventh most populous state among the 50 states and the District of Columbia. By 2025, Ohio is projected to remain the seventh most populous state, with an estimated 11.7 million people. The state is expected to gain 247,000 people through international migration between 1995 and 2025, placing it 16th for net gains through international migration.

Geographic Distribution An estimated 81.1 percent of the population resides in metropolitan areas. The ten counties with the largest populations are Cuyahoga, Franklin, Hamilton, Montgomery, Summit, Lucas, Stark, Butler, Lorain, and Mahoning. The Ohio Family Health Survey categorized the 88 counties as metropolitan (12), suburban (17), rural non-Appalachian (30), and Appalachian (29).

Race/Ethnicity In 1998, 87.1 percent of the population was White, 11.5 percent was Black, 1.1 percent was Asian or Pacific Islander, and 0.2 percent was Native American, Eskimo, or Aleut. These are all

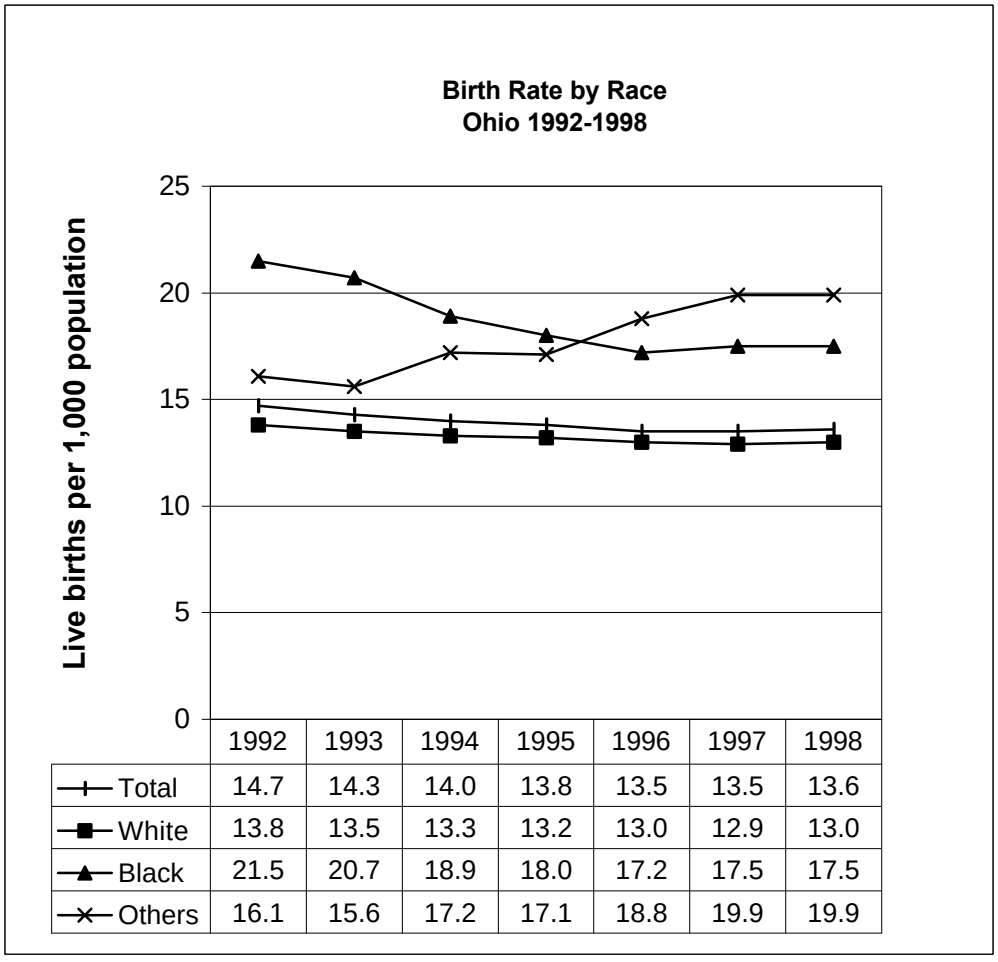
estimates. These groups may include Hispanics, who made up 1.6 percent of the population. The relative percentages of different racial/ethnic groups are not projected to change significantly by 2025.

Age In 1998, the estimated population of children through the age of 21 was 3,478,207, representing 31 percent of the total population. Youth as a percentage of the state population is projected to continue to decrease. This trend is consistent with the national trend.



A.3 Birth Rate

Overall The crude birth rate decreased slightly from 6.7/1,000 total population in 1994 to 6.2/1,000 total population in 1998. The number of resident live births in 1998 was 152,457.



	1992	1993	1994	1995	1996	1997	1998
Total	14.7	14.3	14.0	13.8	13.5	13.5	13.6
White	13.8	13.5	13.3	13.2	13.0	12.9	13.0
Black	21.5	20.7	18.9	18.0	17.2	17.5	17.5
Others	16.1	15.6	17.2	17.1	18.8	19.9	19.9

Teen Births to mothers under age 20 accounted for 13 percent (19,617) of all births in 1998. The teen birth rate declined from 33.1 births/1,000 teenage females ages 15 through 17 in 1994 to 26.6 in 1998. The 1998 rate is lower than the national rate of 30.4. In 1997, Black females represented about 14 percent of the female population ages 10 through 19 and gave birth to 28 percent of all infants born to teen mothers in 1997. White females represented about 85 percent of the female population in this age group and gave birth to nearly 71 percent of all infants born to teen mothers in 1997.

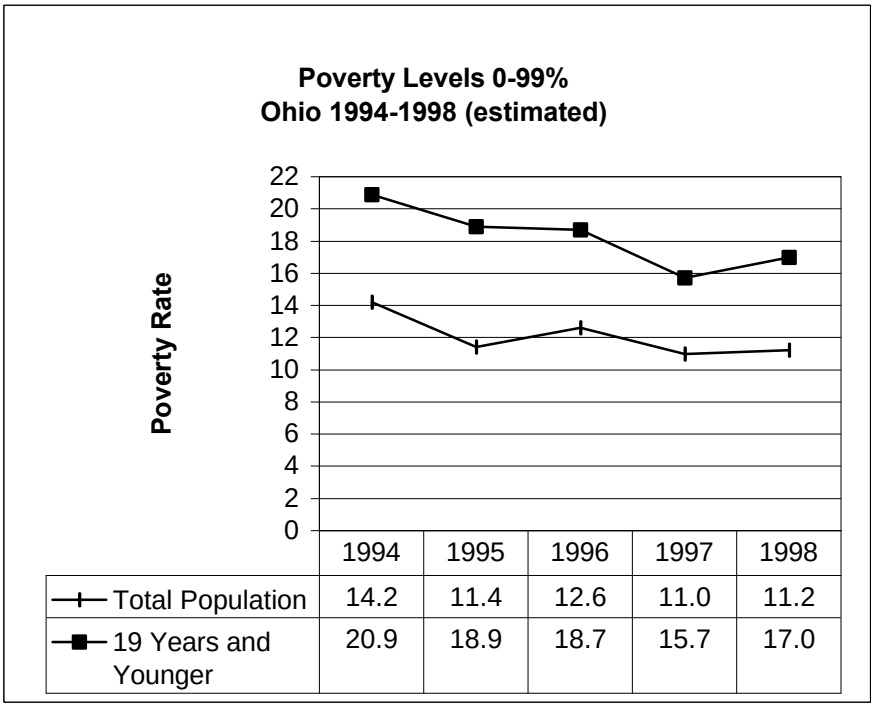
A.4 Family Characteristics

Families Headed by Single Parents The percentage of births to unmarried parents increased from 28.9 in 1990 to 34.0 in 1997. The percentage of families (with and without children) headed by single parents in 1990 was 12.9. This is **higher** than the national percentage of 11 in 1990. (The only data available for this population characteristic are from the 1990 U.S. Census.) In Ohio, 67 percent of Black children live in a family headed by a single parent compared with 25 percent of White children.

A.5 Economic Indicators

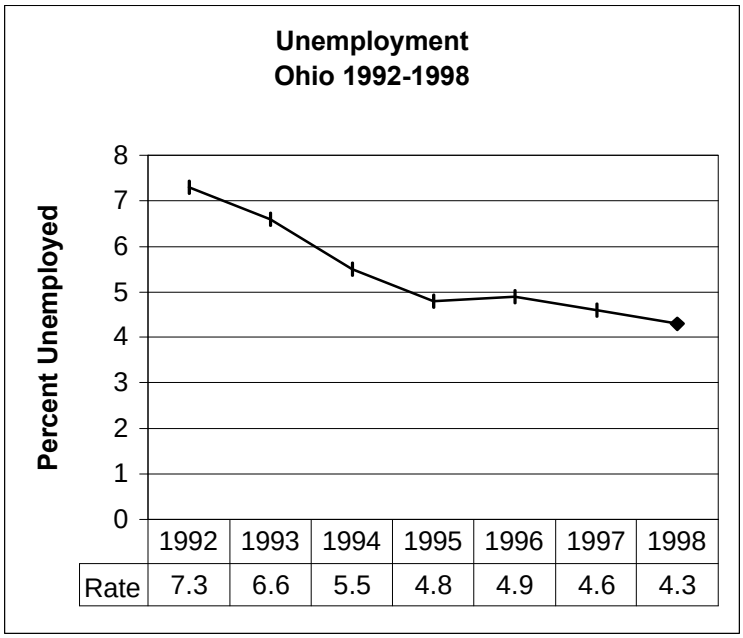
Geographic Although not generally considered a minority group, residents of Appalachia differ from other Ohioans. Until the 1950s, this region had relatively few roads, telephones, or media. A new report by the Central Ohio River Valley Association mapped the mortality rates in southern Ohio's Appalachian counties. This region showed higher death rates due to all causes compared with overall Ohio rates. Factors contributing to this higher rate include poverty, lack of health services, lack of health insurance, and possibly lifestyle and habits of Appalachians.

Poverty Levels: In 1998, 11.2 percent of Ohioans fell below the federal poverty level; this is lower than the national rate of 12.7 percent. Children are the poorest people in Ohio: 17 percent of children 19 and younger lived below the poverty level in 1998. This percentage is lower than the national rate of 18.9 percent. The rate for the total population decreased from 1994 (14.2 percent) through 1998. The rate for children 19 and younger decreased from 1994 (20.9 percent) through 1998.



	1994	1995	1996	1997	1998
Total Population	14.2	11.4	12.6	11.0	11.2
19 Years and Younger	20.9	18.9	18.7	15.7	17.0

Unemployment The unemployment rate in Ohio was 4.3 percent in 1998, which is **lower** than the national average of 4.5 percent. The rate decreased from 1992 (7.3 percent) through 1998.



	1992	1993	1994	1995	1996	1997	1998
Rate	7.3	6.6	5.5	4.8	4.9	4.6	4.3

Food Stamp Recipients: The number of children from birth through age 21 enrolled in the Food Stamp program for 1997 was 484,144. For 1998, enrollment was 408,477. For children from birth through age 17, enrollment was 439,909 in 1997 and 374,319 in 1998.

Children on Public Insurance: The number of children from birth through age 18 eligible for Medicaid decreased from 1995 (853,112) to 1998 (715,280). The number of children eligible for Medicaid at some point from 1995 through 1998 was 3,170,328. The number of children from birth through age 18 eligible for the State Children's Health Insurance Program (SCHIP) in 1998 was 39,229. (When applied to the Medicaid program, the term *eligible* is equivalent to *enrolled.*)

B. **Maternal and Infant Health Status**

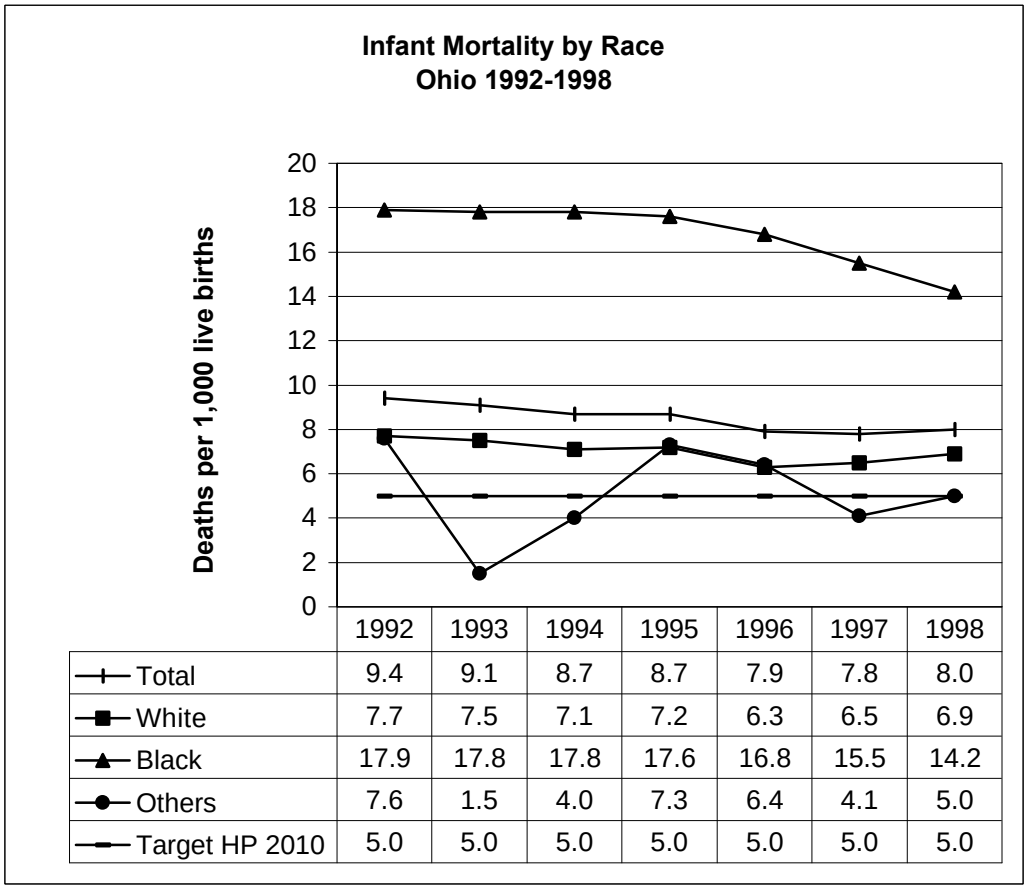
B.1 **Mortality**

Infant Mortality

Description Infant mortality is the death of an infant under one year of age. The leading causes of infant death in Ohio are disorders relating to short gestation, congenital anomalies, and Sudden Infant Death Syndrome (SIDS).

Quantitative Data The infant mortality rate (IMR) is the number of deaths per 1,000 live births in a given year. In 1998, 1,208 infants in Ohio died before they reached their first birthday. This represents a rate of 8.0, which is **higher** than the national rate of 7.2. The Ohio rate also is **higher** than the HP 2000 target rate of 7.0 and the HP 2010 target rate of 5.0. The rate decreased overall from 1992 (9.4) through 1998. It stayed level from 1996 through 1997 and increased slightly in 1998.

Racial Disparities The 1998 IMR for Black infants was over two times the rate for White infants (14.2 vs. 6.9). This disparity is consistent with national data. Also paralleling the national trend, the Black IMR in Ohio has consistently decreased since 1992. The White IMR in Ohio decreased until 1996, then increased that year and in 1997 and 1998. This recent upward trend is inconsistent with national data. The proportional discrepancy between the rates for Black and White infants in Ohio declined from 1995 through 1998; nationally this disparity is increasing.



	1992	1993	1994	1995	1996	1997	1998
Total	9.4	9.1	8.7	8.7	7.9	7.8	8.0
White	7.7	7.5	7.1	7.2	6.3	6.5	6.9
Black	17.9	17.8	17.8	17.6	16.8	15.5	14.2
Others	7.6	1.5	4.0	7.3	6.4	4.1	5.0
Target HP 2010	5.0	5.0	5.0	5.0	5.0	5.0	5.0

Neonatal Mortality

Description Neonatal mortality is the death of an infant under the age of 28 days. Nearly two-thirds of all infant deaths occur during the neonatal period. The leading causes of neonatal death are disorders related to short gestation and low birth weight (LBW), congenital anomalies, respiratory distress syndrome, and complications of pregnancy.

Quantitative Data The neonatal mortality rate (NMR) is the number of infants who die during the neonatal period per 1,000 live births in a given year. In 1998, 813 children of this age died. The NMR was 5.3, which is **higher** than the national rate of 4.8. The Ohio rate also is **higher** than the HP 2000 target rate of 5.0 and the HP 2010 target rate of 3.3. The rate decreased overall from 1992 (5.9) through 1998. However, it stayed level in 1996 and 1997, and increased slightly in 1998.

Racial Disparities In 1998, the NMR for Blacks was almost double the NMR for Whites (8.9 vs. 4.7). This disparity is consistent with national data. The rate for all races remained relatively constant from 1992 until 1995. The rate decreased from 1995 to 1996 and showed a slight upward trend in the total and White rates from 1997 to 1998. The NMR for Blacks showed the most significant decrease since 1995.

 *See* graph after Perinatal Mortality.

Postneonatal Mortality

Description: Postneonatal mortality is the death of an infant from 28 days old to less than one year old. One-third of infant deaths occur during the postneonatal period. After the first month of life, SIDS is the leading cause of infant mortality, accounting for about one-third of all deaths during the postneonatal period. The causes of SIDS are unknown, but risk factors include maternal smoking, drug use, teenage birth, and infections late in pregnancy.

Quantitative Data The rate of postneonatal mortality is the number of infants who die during the postneonatal period per 1,000 live births in a given year. In 1998, 400 children in this age group died. The postneonatal mortality rate was 2.6, which is **higher** than the national rate of 2.5. The Ohio rate also is **higher** than the HP 2000 target rate of 2.4 and the HP 2010 target rate of 1.7. The rate decreased from 1992 (3.5) through 1998. However, it stayed level in each of the years 1996, 1997, and 1998.

Racial Disparities Like the IMR and NMR, the postneonatal mortality rate is higher for Blacks than for Whites. In 1998, the rate for Blacks was over two times higher than the rate for Whites (5.3 vs. 2.2).

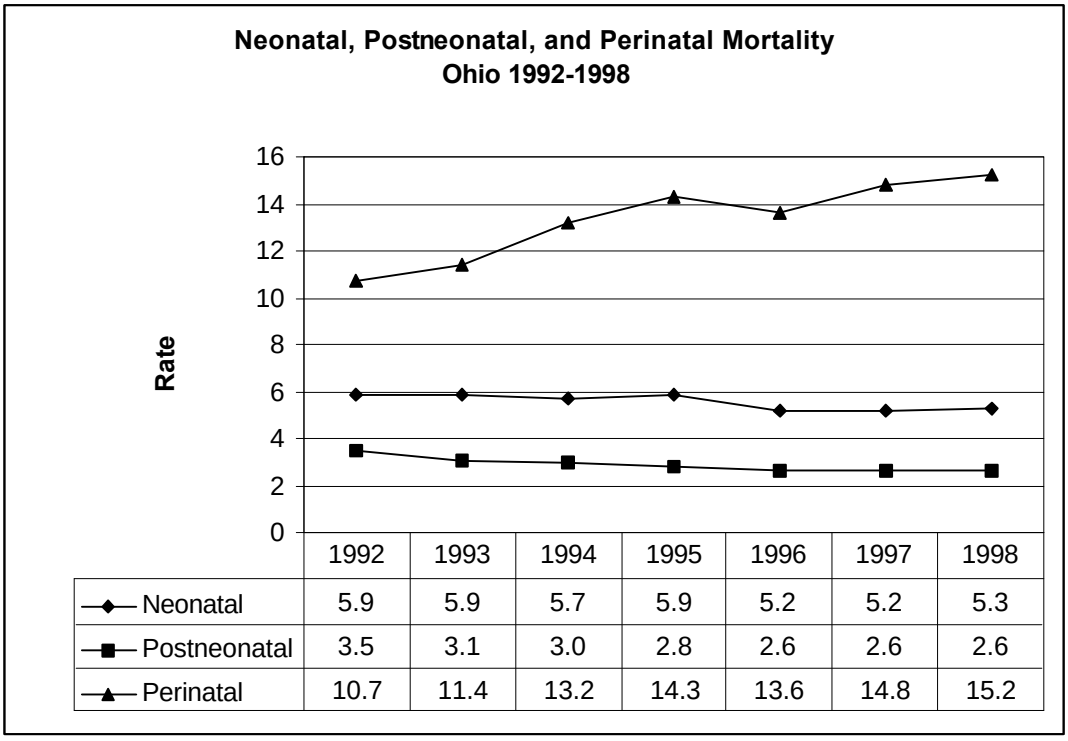
 *See* graph after Perinatal Mortality.

Perinatal Mortality

Description: Perinatal mortality is the death of a fetus/infant during the perinatal period (20 weeks gestation to 7 days after birth). Fetal deaths can be associated with complications of pregnancy, such as maternal blood disorders and problems with amniotic fluid levels. Substance use during pregnancy increases the risk for fetal death: the rate is 33 percent greater in women who smoke and 77 percent greater in women who use alcohol.

Quantitative Data In Ohio, the perinatal mortality rate is the number of fetuses/infants who die during the perinatal period per 1,000 live births and fetal deaths in a given year. This definition is different from the national definition and the Healthy People 2010 definition, making comparisons difficult. In Ohio, fetal death is defined as death prior to the complete expulsion or extraction from its mother of a product of conception, of at least 20 weeks gestation (including induced abortions). In 1998, the perinatal mortality rate was 15.3. The rate increased from 1992 (12.0) through 1998. During this period, the rate peaked at 15.6 in 1995. It dropped to 14.8 in 1996 and began rising again in 1997. The national rate was 7.5 in 1997 (perinatal period defined as 28 weeks gestation to 7 days after birth), and the HP 2010 target rate is 4.5 (same definition as national).

Racial Disparities: The perinatal mortality rate is more than twice as high for Black infants as for White infants (30.3 vs. 12.6 in 1998). In 1994, the gap widened from 2.1 times higher to 2.5 times higher and has stayed relatively level.



	1992	1993	1994	1995	1996	1997	1998
Neonatal	5.9	5.9	5.7	5.9	5.2	5.2	5.3
Postneonatal	3.5	3.1	3.0	2.8	2.6	2.6	2.6
Perinatal	10.7	11.4	13.2	14.3	13.6	14.8	15.2

Maternal Mortality

Description: Maternal mortality in the United States is rare: in 1997, 327 maternal deaths were reported. The leading causes of maternal mortality are ectopic pregnancy, pre-eclampsia/eclampsia, hemorrhage, embolism, and infection.

Quantitative Data Ohio uses the Centers for Disease Control (CDC) and American College of Obstetrics and Gynecology (ACOG) definition of maternal mortality: death of a woman while pregnant or within one year of termination of pregnancy (live or stillbirth), irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or her management, but not from accidental or incidental causes. In 1998, nine women died from causes related to maternity, for a rate of 5.9/100,000 live births. This rate is **higher** than the HP 2000 target rate of 3.3. In 1992, seven women died, for a rate of 4.3. Because of the small numbers of deaths, use caution when interpreting rates. The numbers are probably underreported because Ohio currently uses only the vital statistics system to report maternal mortality.

Racial/Ethnic Disparities: The maternal mortality rate for Whites increased from 3.0 in 1992 to 3.2 in 1998. In that period, the rate for Blacks increased from 11.6 to 22.1. No maternal deaths were reported for Hispanics from 1992 through 1998. The rate increased for non-Hispanics from 4.4 in 1992 to 5.4 in 1998. Again, use caution when interpreting these rates due to the small numbers.

Age Disparities In 1998, the age group with the highest maternal mortality rate was 18 through 19 years, with a rate of 14.6. No maternal deaths were recorded among women in these age groups: younger than 15 years, 15 through 17 years, and 35 years and over.

B.2 Morbidity

Low Birth Weight

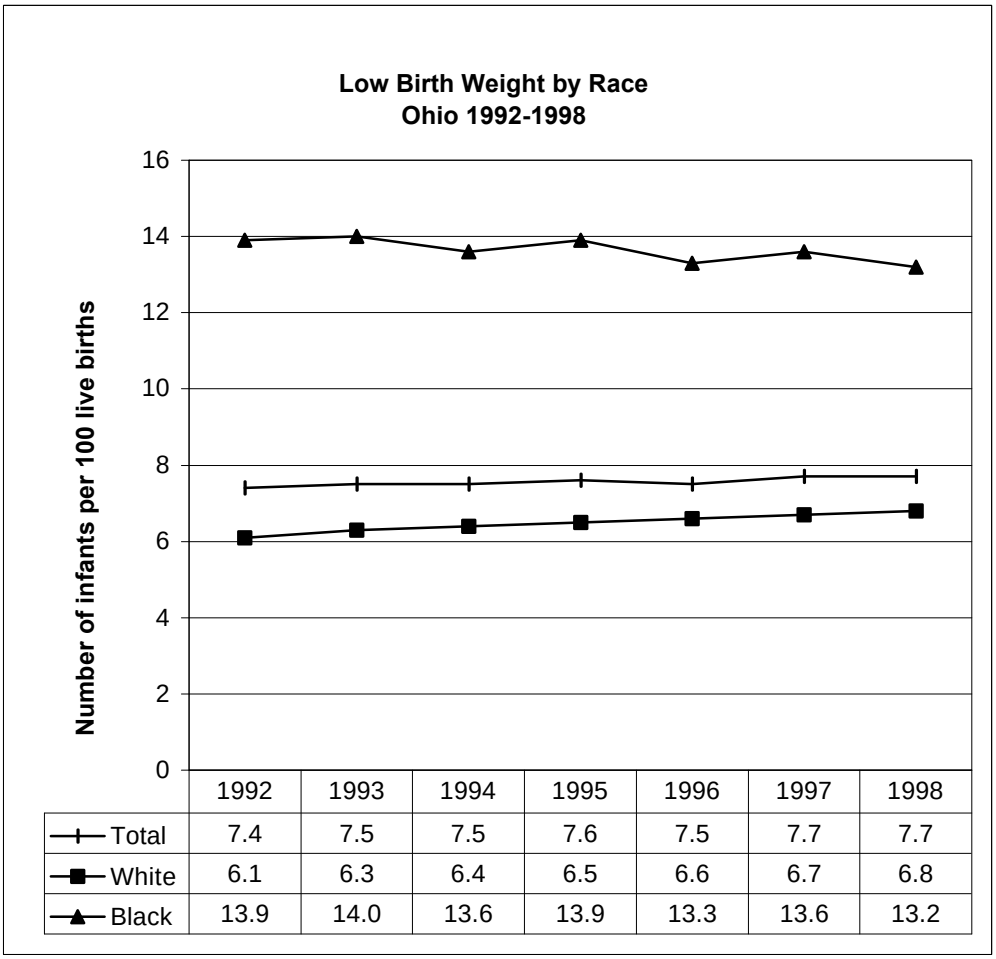
Description Low birth weight (LBW) is a weight of less than 2,500 grams (about 5.5 pounds) at birth. LBW is the factor most closely associated with neonatal mortality. Infants with LBW are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight. Disabilities include cerebral palsy, autism, developmental delay, vision and hearing impairments, and other developmental disabilities. Despite the low prevalence of LBW, expenditures for the care of LBW infants total more than half of the costs incurred for all newborns.

Maternal Risk Factors Factors associated with increased risk of LBW include smoking, poverty, minority status, low level of educational attainment, prior LBW history, low prepregnancy weight, multiple births, vaginal infections, and domestic violence. Nationally, 12 percent of infants born to women who smoked during pregnancy were LBW compared with 7 percent of births to non-smokers.

Quantitative Data The LBW rate is the percentage of infants born with LBW in a given year. In 1998, the rate was 7.7 percent. This is **higher** than the national rate of 7.5 percent and **higher** than the HP 2000 and HP 2010 target rate of 5.0 percent. The rate increased from 1992 (7.4 percent) through 1998.

Racial Disparities The White rate increased from 6.1 percent in 1992 to 6.8 percent in 1998. Although the rate among Black infants dropped from 13.9 percent in 1992 to 13.2 percent in 1998, these rates are more than twice those of White infants. All of these trends are consistent with national data.

Age Disparities The highest rate of LBW is among teens under age 15. The rate for these teens decreased from 15.2 percent in 1992 to 11.7 percent in 1998. However, the numerator and denominator for these rates are low; therefore, the rates should be interpreted with caution. The rates of LBW among teens in age groups 15 through 17 years and 18 through 19 years remained level from 1992 through 1998. The lowest rate is for the 25 through 34 year age group. This rate increased slightly from 6.4 percent in 1992 to 6.9 percent in 1998. The rate for mothers 35 years and over slowly increased from 8.1 percent in 1992 to 9.1 percent in 1998.



	1992	1993	1994	1995	1996	1997	1998
Total	7.4	7.5	7.5	7.6	7.5	7.7	7.7
White	6.1	6.3	6.4	6.5	6.6	6.7	6.8
Black	13.9	14.0	13.6	13.9	13.3	13.6	13.2

Very Low Birth Weight

Description: Very low birth weight (VLBW) is a weight of less than 1,500 grams (about 3.3 pounds) at birth. Although infants weighing less than 1,500 grams account for a small percentage of births, they account for up to half of the deaths of newborns. Nearly 90 percent of the very smallest infants (less than 500 grams) die within the first year of life. VLBW infants who survive are at significantly increased risk of severe problems, including physical and visual difficulties, developmental delays, and cognitive impairment. These conditions all require increased levels of medical, educational, and parental care.

Maternal Risk Factors: VLBW is usually associated with preterm birth. Relatively little is known about risk factors for preterm birth, but the primary risk factors are prior preterm birth, prior spontaneous abortion, low prepregnancy weight, and cigarette smoking during pregnancy. However, these risk factors account for only one-third of all preterm births. Substance use during pregnancy also may increase the risk of preterm birth. Many of the risk factors can be lessened or prevented with good preconception and prenatal care.

Quantitative Data The VLBW rate is the percentage of infants born with VLBW in a given year. In 1998, the rate was 1.5 percent. This is **higher** than the national rate of 1.4 percent and **higher** than the HP 2000 and HP 2010 target rate of 1.0 percent. The rate increased from 1992 (1.3 percent) through 1998.

Racial Disparities The White rate increased slightly from 1992 to 1998 (1.0 percent to 1.3 percent) while the Black rate decreased slightly in the same period (3.1 percent to 2.9 percent). The rate for Blacks is still more than twice the rate for Whites. This disparity is a major contributor to the disparity in IMRs between Black and White infants.

Age Disparities The rates of VLBW by maternal age follow the same pattern as LBW rates.

Perinatal Transmission of HIV and Other Sexually Transmitted Infections

Description The majority of pediatric (under 13 years old) AIDS cases results from transmission during the perinatal period (before or during birth). The number of new cases of pediatric AIDS due to perinatal transmission has declined by 54.2 percent nationally since 1993. A major factor in this decline is the increasing use of zidovudine treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV-positive pregnant women. In 1995, routine HIV voluntary testing and counseling for all pregnant women was recommended.

Quantitative Data In 1998, 25 children were born to HIV-positive women; none of these children has tested positive for HIV. In 1994, 33 children were born to HIV-positive women; 8 developed AIDS. Perinatal transmission of syphilis, gonorrhea, and *Chlamydia* decreased overall from 1994 through 1998. However, gonorrhea and *Chlamydia* showed an increase from 1997 through 1998.

Racial/Ethnic Disparities Of the children under 13 who have HIV and live in Ohio, 57 percent are Black, 28 percent are White, and 13 percent are Hispanic. Race is unknown for 1 percent.

Age Disparities Of pediatric HIV/AIDS cases, 21 percent are ages 0 through 4, 52 percent are ages 5 through 9, and 26 percent are ages 10 through 12.

Gender Disparities Of pediatric HIV/AIDS cases, 44 percent are male and 56 percent are female.

Neural Tube Defects

Description A neural tube defect (NTD) is the defective closure of the neural tube during early growth and development of the embryo. Spina bifida is the most frequently reported NTD, occurring twice as often as anencephalus. About 50 percent of NTDs may be prevented if women receive adequate doses of folic acid before and during pregnancy.

Quantitative Data The NTD rate is the number of neural tube defects per 10,000 live births in a given year. In 1998, 57 infants were born with an NTD. This represents a rate of 3.7, which is **lower** than the national rate of 6.0 and **higher** than the HP 2010 target rate of 3.0. The rate was 4.0 in 1994, rose to 4.9 in 1995, and decreased to 4.6 in 1996 and 4.2 in 1997. The rates actually may be higher because not all NTDs are identified on birth certificates.

Racial Disparities While the rate of NTDs has decreased for all races in 1998, Whites had the highest rate (4.2). That rate is over three times the rate for Blacks (1.3).

Age Disparities In 1998, women 35 years and older had the highest rate of NTDs (4.7). The numbers are too small for each age group to draw conclusions about trends.

B.3 Contributing Factors

Unintended Pregnancy

Description Unintended pregnancies include births that were not wanted at the time of conception (mistimed), births that were not wanted at all, and abortions.

Quantitative Data In 1999, the percentage of unintended pregnancies among women receiving prenatal at CFHS clinics was 81.6. The rate increased from 1995 (79.6 percent) through 1998 (84 percent), then decreased through 1999. The 1995 rate among CFHS clients is **higher** than the 1995 national rate of 49 percent and **higher** than the HP 2010 target rate of 30 percent. Sources of national data include CDC and the National Survey of Family Growth.

Primary Cesarean Section

Description: The method and location of delivery can affect the health of mothers and the likelihood of survival of infants with VLBW. During the 1980s, rates of cesarean deliveries rose steadily. In 1988, the national rate hit a peak of 24.7 percent, then declined to 17.8 percent in 1997. These reductions are likely to be attributable to better education of physicians on the positive prospects for vaginal delivery after cesarean and to other strategies implemented by hospitals to reduce the rates of cesarean sections (C-sections), such as stringent requirements for second opinions. Increasing concern about cost containment within the health

care system also may be an important factor. In addition to increased cost and longer hospital stays, the risks of maternal morbidity and mortality and of perinatal morbidity are greater when infants are delivered surgically.

Quantitative Data The rate of primary C-section is the percentage of infants delivered by this method in a given year to women who have not had a previous C-section. In 1998, this rate was 11.8 percent, which is **lower** than the HP 2010 target rate of 15.5 percent. In 1997, the rate was 12.2 percent, which is **lower** than the national rate of 17.8 percent in 1997 (the latest year for which data are available). The rate decreased from 1992 (13.9 percent) through 1998.

Geographic Disparities In 1998, the Ohio counties with the highest rates of primary cesarean deliveries seemed to be concentrated in the southeastern part of the state.

Prenatal Care

Description: The use of timely, high-quality, prenatal care can help to prevent poor birth outcomes, especially by providing counseling to women who are at high risk of using alcohol, tobacco, and other drugs. The percentage of women who receive first trimester prenatal care has steadily increased since 1990 for all population groups. Adolescents, Black women, and low-income women remain less likely to enter care early and to receive adequate care. The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization Index, is an index of prenatal care based upon month of entry, number of prenatal visits, and gestational age of infant at birth. The index is reported by the following four levels: Inadequate (0 through 49 percent of expected visits), Intermediate (50 through 79 percent), Adequate (80 through 100 percent), and Adequate Plus or Intensive (110 percent or greater). This index does not assess the quality of the prenatal care that is delivered, but rather its utilization.

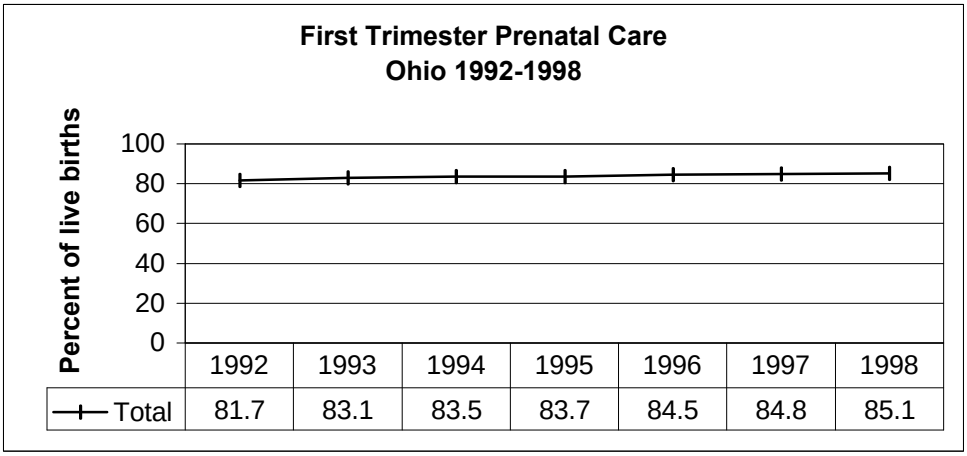
Quantitative Data *First Trimester Prenatal Care:* The rate of first trimester prenatal care is the percentage of births to women who received early prenatal care. In 1998, this rate was 85.1 percent. The 1997 rate was 84.8 percent. This is **higher** than the 1997 national rate of 82.5 percent and **lower** than the HP 2010 target rate of 90 percent. The rate increased from 1992 (81.7 percent) through 1998.
Kotelchuck Index: The rate for 1998 was 48.6 percent for Adequate utilization and 76.3 percent for Adequate and Adequate Plus (combined). The latter rate is **higher** than the 1997 national rate of 73 percent and **lower** than the HP 2010 target rate of 90 percent. The percentage of women with Inadequate prenatal care is decreasing overall. From 1994 through 1998, the percentage for Adequate decreased, and the percentage for Adequate and Adequate Plus increased.

Racial Disparities *First Trimester Prenatal Care:* Among births to Whites, the rate increased from 84.9 percent in 1992 to 87.4 percent in 1998. The rate among births to Blacks increased from 65 percent to 72.4 percent in the same period. The rate among births to other races increased from 81.4 percent in 1992 to 84.2 percent in 1998.

Kotelchuck Index: Black women have adequacy of care levels for Adequate and Adequate Plus that are about one-third that of White women. Black women were three times more likely than White women to have Inadequate levels of care in 1994, but the gap had narrowed to two and a half times by 1998.

Age Disparities *First Trimester Prenatal Care:* From 1992 through 1998, all of the maternal age groups showed an increase in early prenatal care. The proportion rose with maternal age until the late 30s, when it declined slightly.

Kotelchuck Index: Age disparities were not analyzed.



B.4 Qualitative Data—Consumers and Key Informants

ODH solicited primary, qualitative data from Ohio consumers, local health commissioners, and key policy makers (legislators, members of the Governor's Cabinet, key staff from the Office of the Governor) through surveys, interviews, and focus groups. *See Perceived Needs Information in the Appendix for a description of the methodologies, target groups, and information collected.* Below is a summary of perceived needs related to maternal and infant health status issues. Qualitative data related to health services issues are presented in Section 3.1.2.2/3.1.2.3.

- *Health commissioners* indicated that infants with low birth weight was the most important maternal and infant health issue in their communities.
- *Key policy makers* mentioned the following as top unmet health care needs for the state overall and/or their constituents: prenatal care, substance abuse, teen pregnancy, unintended pregnancies, and alcohol abuse.

A summary of the results of the community health assessments conducted by the Child and Family Health Services Projects related to maternal and infant health status issues is presented in B.5 in this section.

B.5 Qualitative Data—Community-Identified

As part of their FY 2000 grant application process, 80 CFHS projects in 81 of Ohio's 88 counties conducted community health assessments based on the *Ohio's Public Health Plan* model. The priority needs identified through these assessments were used to develop county-level program plans. Each plan addresses any combination of MCH performance measures and up to two performance measures proposed by the county and related to the MCH population. Interventions and activities were designed using the framework of the core public health services of infrastructure building, population-based, enabling, and direct health care. The results of these local community health assessments help to complete the picture of MCH needs in Ohio. Qualitative data related to health services issues are presented in Sections 3.1.2.2/3.1.2.3. (*See* Section 3.1.2.2/3.1.2.3 A.2 *The Safety Net of Health Care Services* for more information on the CFHS projects.) Below is a summary of findings from the community health assessments related to maternal and infant health status issues.

- At least half or more of the counties identified early prenatal care and teen births as their highest priority maternal and infant health (status) issues.
- Between a quarter and half of the projects identified the following issues as priorities they would address in their communities: prenatal smoking, adequate prenatal care, breastfeeding, and unintended pregnancy.

C. Child and Adolescent Health Status

C.1 Mortality

Overall Mortality Ages 1 Through 4

Description Nationally, injuries accounted for 43.3 percent of all deaths in children ages 1 through 4 in 1998. Motor vehicle crashes, drowning, and fire were the leading causes of injury. In Ohio, the leading causes of death for children ages 1 through 9 (1996 data) are as follows: (1) motor vehicle crashes, (2) malignant neoplasms, (3) congenital anomalies, (4) unintentional injuries caused by fires and flames, and (5) unintentional injuries caused by submersion and suffocation.

Quantitative Data In 1998, the mortality rate for children ages 1 through 4 was 32.3/100,000 in that age group, which is **lower** than the national rate of 34.2 and **higher** than the HP 2010 target rate of 25. The rate decreased from 1994 (40.9) through 1998.

Racial/Ethnic Disparities The mortality rate decreased for both Whites and Blacks from 1994 through 1998, though the rate is still higher among Blacks.

See graph after Overall Mortality Ages 15 Through 19

Overall Mortality Ages 5 Through 14

Description Nationally, injuries accounted for 51.4 percent of all deaths in children ages 5 through 14 in 1997. Motor vehicle crashes were the leading cause of death from injury, followed by firearm deaths. About 52 percent of firearm deaths were homicides. In Ohio, the top causes of death for children ages 5 through 14 are as follows: (1) motor vehicle crashes, (2) malignant neoplasms, (3) unintentional injuries caused by submersion, suffocation, and foreign bodies, (4) homicide and intentional injuries inflicted by other persons, (5) congenital anomalies [note: this cause tied with #4], and (6) suicide and self-inflicted injuries.

Quantitative Data In 1998, the mortality rate for children ages 5 through 14 was 19.7/100,000 in that age group, which is **higher** than the HP 2010 target rate of 17. In 1998, the Ohio rate for children ages 5 through 9 was 19.2, compared with 17.6 nationally. The Ohio rate increased overall from 1994 through 1998; it was 17.8 in 1994, rose to 20.4 in 1995, then decreased to 17.3 in 1996 before rising again to 17.7 in 1997. The Ohio rate for children ages 10 through 14 was 21.8, compared with 20.2 nationally. The Ohio rate decreased overall from 1994 (22.6) through 1998.

Racial Disparities The mortality rate for Whites was 19.3, compared with 22.7 for Blacks.

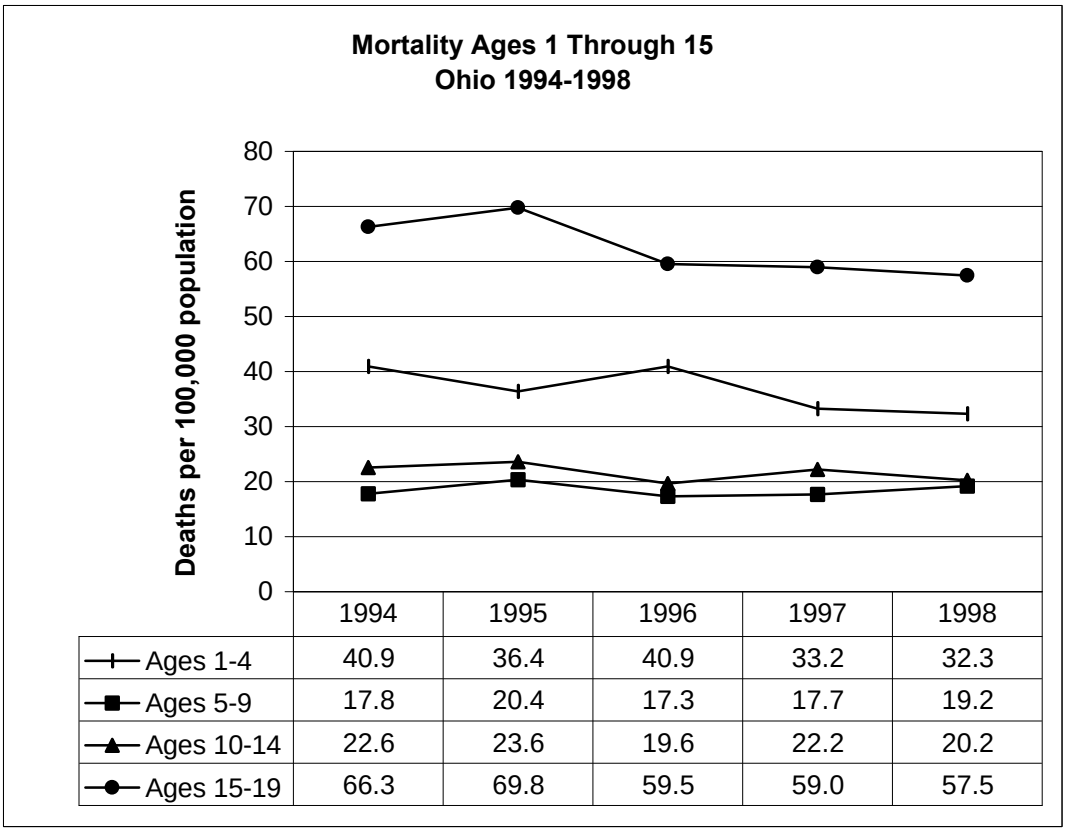
See graph after Overall Mortality Ages 15 Through 19

Overall Mortality Ages 15 through 19

Description Nationally, injury was the leading cause of death for adolescents ages 15 through 19 in 1997, accounting for 46 percent of all deaths in that age group. This is consistent with Ohio data, which reveal that the three top causes of death are injuries: (1) motor vehicle crashes, (2) suicide and self-inflicted injuries, and (3) homicide. After injuries, malignant neoplasm is the next leading cause of death—nationally and for Ohio—accounting for about 5 percent of deaths.

Quantitative Data In 1998, the mortality rate for adolescents ages 15 through 19 was 57.5/100,000 in this age group, which is **lower** than the national rate of 69.7. The Ohio rate decreased from 1994 (66.3) through 1998. A comparison to HP 2000 cannot be made directly because the HP 2000 target rate is 85 for individuals ages 15 through 24 years.

Racial Disparities The overall gap between the mortality rate for Whites and Blacks decreased from 1994 through 1998. However, the rate for Blacks was still higher than that for Whites in 1998 (85.5 vs. 55.6).



	1994	1995	1996	1997	1998
Ages 1-4	40.9	36.4	40.9	33.2	32.3
Ages 5-9	17.8	20.4	17.3	17.7	19.2
Ages 10-14	22.6	23.6	19.6	22.2	20.2
Ages 15-19	66.3	69.8	59.5	59.0	57.5

Mortality Due to Motor Vehicle Crashes for Children and Youth

Description Injury is the leading cause of death in children and youth. Motor vehicle (MV) crashes were the leading cause of mortality from injury, accounting for almost 80 percent of all injury deaths among teenagers.

Quantitative Data *Children Ages 1 Through 14:* In 1998, the mortality rate from MV crashes was 4.4/100,000 in this age group. This rate is **higher** than the national rate of 4.2, **equals** the HP 2000 target rate of 4.4, and is **higher** than the HP 2010 target rate of 2.1. The rate increased slightly from 1994 (4.3) through 1998, with a decline in 1996 (3.9).

Youth Ages 15 Through 24: In 1998, the mortality rate for adolescents ages 15 through 24 from MV crashes was 23.6/100,000 in this age group. This rate is **lower** than the national rate of 25.4, **lower** than the HP 2000 target rate of 26.8, and **higher** than the HP 2010 target rate of 9.0. The rate rose from 1994 (21.9) through 1995 (25.8), then decreased in 1996 (24.6) and 1997 (24.2).

Gender Disparities In the 1 through 14 year age group, deaths from MV crashes were more common among males than females from 1994 to 1997; more females were killed in 1998. Mortality rates for MV crashes were steady from 1996 through 1998 for males and females in the 15 through 24 year age group.

Suicide Deaths and Suicide Attempts Among Adolescents

Description Over 12 percent of deaths in this age group are due to suicide.

Quantitative Data *Suicide Deaths:* In 1998, the rate of suicides among youths ages 15 through 19 was 8.7/100,000 in this age group. This rate is **lower** than the national rate of 9.7 for this age group. There are no HP objectives for this health issue. From 1994 through 1998, the rate reached a low of 6.2 in 1996. The rate increased slightly since then, but was still lower in 1998 than in 1994 (11.6).

Suicide Attempts: The data for this health issue come from the Youth Risk Behavior Survey (YRBS). In 1997, 10 percent of students in grades 9 through 12 reported that they had attempted suicide one or more times during the 12 months prior to the survey. This rate is **higher** than the national YRBS rate of 7.7 percent and **higher** than the HP 2010 target rate of 1.8 percent. The rate decreased slightly from 1993 (11 percent).

Racial Disparities *Suicide Deaths:* The suicide rate in this age group is similar for Whites (9.0) and Blacks (8.8).

Suicide Attempts: Ten percent of White and Black students, and 20 percent of students in other race categories attempted suicide in 1997.

Gender Disparities *Suicide Deaths:* The rate is highest among males for all racial and ethnic groups. In 1998, 66 males committed suicide, compared with only 8 females in the same age group.

Suicide Attempts: Significantly more females (15 percent) than males (6 percent) attempted suicide.

C.2 Environmental—Morbidity

Elevated Blood Lead Levels

Description: High blood lead levels are among the most prevalent childhood conditions and the most prevalent environmental threat to the health of children. An elevated blood lead level is defined as greater than or equal to 10 micrograms per deciliter. Childhood lead poisoning is totally preventable. However, lead in paint, dust, and soil has been reduced only to a limited extent. Lead in the home environment is the major remaining source of human lead exposure. Health effects of high levels of lead include coma, convulsions, developmental delay, seizures, and death. Lower levels of exposure can result in chronic impairment of the central nervous system, including decreased cognitive development, reduced IQ, and growth deficiency. Children between 0 and 6 years of age are at highest risk for the negative physiological effects of lead poisoning.

Quantitative Data The percentage of children screened (ages 6 months to 6 years) who had elevated blood lead levels was 8.0 percent for 1996, 7.0 percent for 1997, and 9.1 percent for 1998. These rates are **higher** than the national rate of 4.4 percent. The HP 2010 objective is to eliminate elevated blood lead levels in children. The state and national rates are not directly comparable because the Ohio rate reflects *mostly* new cases (and some previously confirmed), while the national rate measures true prevalence. However, this comparison gives a fairly good indication of the state rate relative to the national rate

because Ohio is considered a high-risk state for elevated blood lead levels. This is due to the number of older homes in both rural and inner city areas.

C.3 Infectious Diseases—Morbidity

Chlamydia in Adolescents Ages 15 through 19

Description *Chlamydia* is the most common sexually transmitted infection (STI). STI rates are highest among the teenage population, especially females. Ohio ranks 16th out of all states in cases of *Chlamydia*.

Quantitative Data In 1998, the rate of *Chlamydia* infections in the 15 through 19 year age group was 2,732/100,000 individuals in that age group. This prevalence rate of 2.7 percent is **lower** than the HP 2010 objective of 3 percent. The rate decreased slightly from 1994 (2.9 percent) through 1998.

Racial/Ethnic Disparities Blacks have the highest rate of *Chlamydia*, followed by Hispanics and Whites.

Gender Disparities Females have a higher rate than males, probably because of increased testing.

AIDS in Adolescents and Adults

Description Nationally, AIDS cases among women make up approximately 20 percent of total cases. The incidence among men is decreasing, while the incidence among women is increasing.

Quantitative Data In 1998, the Ohio incidence rate of AIDS was 5.1/100,000 individuals 13 years and older. This rate is **lower** than the national rate of 19.5 for this age group and **lower** than the HP 2010 target rate of 12.0. The rate decreased overall from 1994 through 1998.

Racial/Ethnic Disparities In Ohio and nationally, the AIDS rate among Blacks is seven times higher than among Whites. The average of the rates from 1996 through 1998 is 24.3 for Blacks, 17.9 for Hispanics, and 3.5 for Whites.

Age Disparities The highest incidence of AIDS occurs in the 30 through 39 year age group.

Gender Disparities In 1998, 43 percent of AIDS cases in Ohio were in male homosexuals. The incidence rates were 10.3 for men and 1.8 for women. Nationally, females ages 13 through 19 accounted for 50 percent of newly reported AIDS cases; 53 percent of these acquired HIV through heterosexual contact.

Vaccine-Preventable Diseases

Description Widespread vaccination of children has resulted in decreases in morbidity and mortality due to vaccine-preventable diseases. An HP 2010 objective for vaccine-preventable diseases is the elimination of congenital rubella syndrome, diphtheria, measles, mumps, polio, rubella, tetanus, and invasive disease caused by *Haemophilus influenzae* type b (Hib).

Quantitative Data No cases of diphtheria, poliomyelitis, or rubella (not congenital) have been reported since 1994. The number of cases of other vaccine-preventable diseases declined overall from 1993 through

1998. In 1998, 299 cases of pertussis, 48 cases of disease caused by Hib (in children under age 5), 29 cases of mumps, and 1 case of measles were reported.

C.4 Infectious Diseases—Contributing Factors

Teen Sexual Intercourse

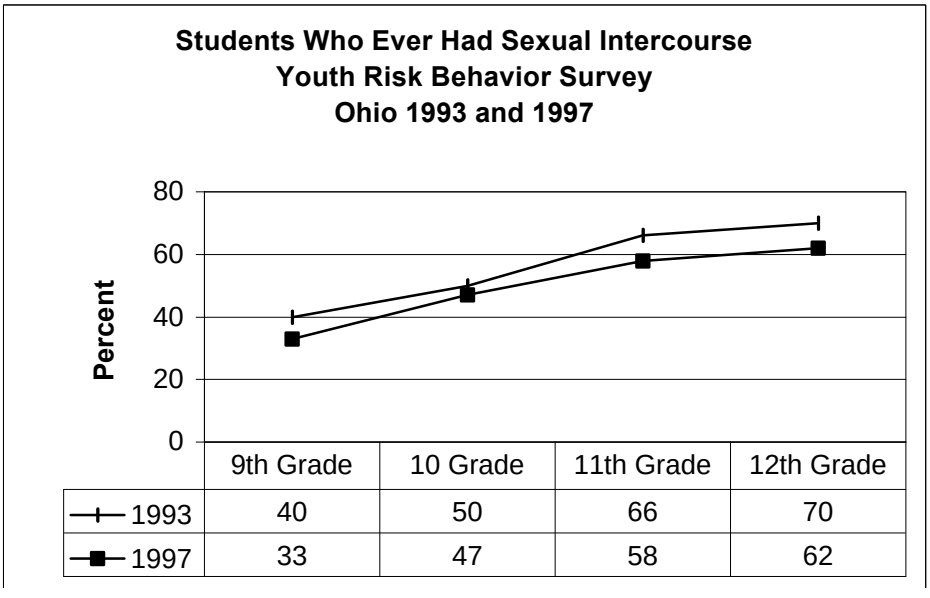
Description Sexual experience, and particularly age at first intercourse, represents a critical risk factor for pregnancy and STIs, including HIV/AIDS. Sexual intercourse is defined as heterosexual, vaginal intercourse. Youths who begin having sex at younger ages are exposed to these risks over a longer time. Research has shown that youths who have early sexual experiences are more likely at later ages to have more sexual partners and more frequent intercourse.

Quantitative Data The data for this health issue come from the YRBS. In 1997, 49 percent of students in grades 9 through 12 reported ever having sexual intercourse. The rate decreased from the 1993 survey (55 percent). Similarly, the percentage of students who reported having sexual intercourse for the first time before age 13 decreased from 11 percent in 1993 to 9 percent in 1997.

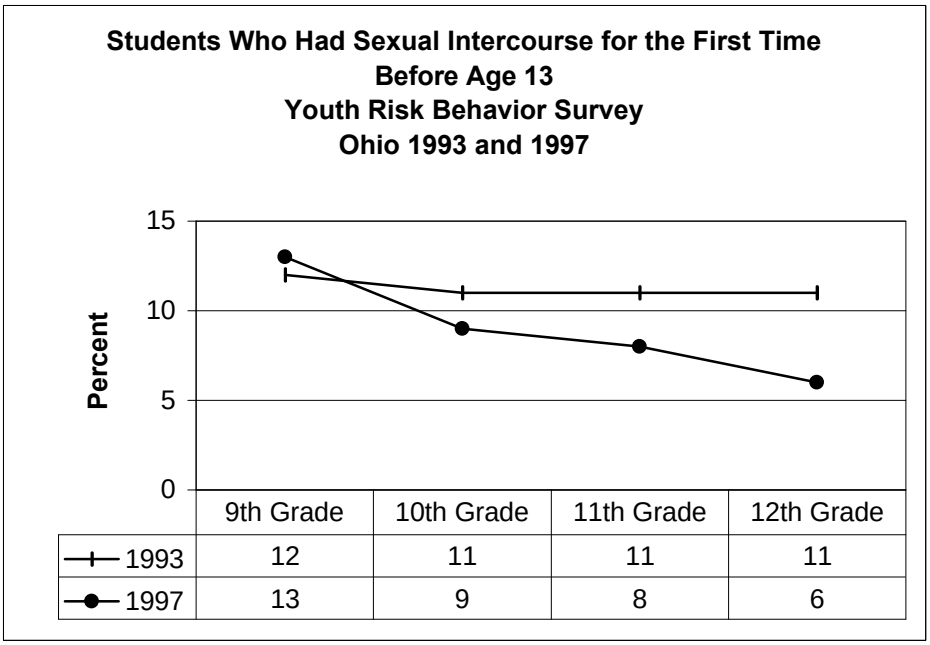
Racial Disparities The percentage of Black teens who ever had sexual intercourse was higher than White teens (82 vs. 48 in 1993 and 73 vs. 42 in 1997). The percentages for Black teens who had sexual intercourse for the first time before age 13 also were higher (26 vs. 8 in 1993 and 22 vs. 5 in 1997).

Age Disparities The percentage of teens who ever had sexual intercourse increased with grade level. In 1997, the percentages were 33 for ninth graders, 47 for tenth graders, 58 for eleventh graders, and 62 for twelfth graders. The percentages of teens at each grade level who reported they had sexual intercourse for the first time before age 13 decreased in 1997: 13 for ninth graders, 9 for tenth graders, 8 for eleventh graders, and 6 for twelfth graders. This trend was not observed in the 1993 survey; all teens reported 11 to 12 percent.

Gender Disparities The percentages were about equal for males and females who ever had sexual intercourse. A higher percentage of males had sexual intercourse for the first time before age 13 (17 for males vs. 5 for females in 1993 and 14 for males vs. 5 for females in 1997).



	9th Grade	10 Grade	11th Grade	12th Grade
1993	40	50	66	70
1997	33	47	58	62



C.5 Injuries—Morbidity

Nonfatal Motor Vehicle Injuries in Children and Youth

Description Motor vehicle crashes are a major cause of injuries in children and youth.

Quantitative Data *Children Ages 0 Through 15:* In 1998, the rate of nonfatal injuries was 969/100,000 children ages 0 through 15. The state rate cannot be compared with the national rate due to a difference in data sources. The HP 2010 objective to reduce nonfatal injuries caused by motor vehicles applies only to the 16 through 20 and 21 through 24 year age groups.

Youth Ages 16 Through 25: In 1998, the rate of nonfatal injuries was 4,103/100,000 individuals ages 16 through 25. This rate is **higher** than the 1997 national rates of 3,116 for ages 16 through 20 and 2,496 for ages 21 through 24. The Ohio rate also is **higher** than the HP 2010 target rate of 953 for ages 16 through 20 and 21 through 24.

Age Disparities The highest rate of injuries is in the 16 through 20 year age group. This rate is 30 to 40 percent higher than the next highest rate, which is in the 21 through 25 year age group. The next highest rate of injuries is in the 11 through 15 year age group (1,195). From 1994 through 1998, the rate for this age group has consistently been about 30 percent higher than the 0 through 5 and 6 through 10 year age groups.

Child Abuse and Neglect

Description Child abuse is any mistreatment or neglect of a child that results in non-accidental harm or injury and that cannot be reasonably explained. Child abuse can include physical abuse, emotional abuse, sexual abuse, and neglect. About three-quarters of all child abuse is committed by the child's parents. Contributing factors to child abuse include immaturity of parents, lack of parenting skills, unrealistic expectations, prior abuse of parent, social isolation, and problems with alcohol or illicit drugs. Violent and abusive behaviors continue to be major causes of death, injury, and stress in the United States; child abuse and neglect increased more than 85 percent from the baseline in 1987. Children who have been maltreated are more likely to be involved in delinquent and violent behaviors during adolescence.

Quantitative Data The rate of child abuse is the number of incidents per 1,000 children under 18 years. The Ohio rate of child abuse was 10.4 in SFY 1998 and 6.3 in SFY 1999. These represent substantiated incidents of child abuse only. (An incident may have multiple victims.) Comparisons of the Ohio rate to national rates and to HP target rates are difficult because of the differences in definition and data collection. These rates are **lower** than the 1997 rate of 13.9 reported through the National Child Abuse and Neglect Data System, which reports substantiated and indicated child abuse. The HP 2010 objective for child abuse relates only to deaths from child abuse. The Ohio rate of substantiated incidents decreased overall from 1995 (13.8) through 1998; however, this may be due to differences in reporting of child abuse.

Geographic Disparities Comparing rates among counties is difficult because each county has its own screening process. The counties with the lowest percentages of substantiated abuse are located in the Appalachian region, with the exception of Summit County. All of these counties have a high rate of reporting suspected abuse to the children's service agency. The counties with the highest percentages of substantiated abuse are Holmes and Jefferson.

C.6 Nutrition—Morbidity

Overweight in Children Younger than 5 Years

Description Overweight is defined as a weight-for-height above the 95th percentile of the National Center for Health Statistics age-and-sex-specific weight-for-height reference population. The health problems associated with childhood overweight and obesity include high blood pressure, high cholesterol, glucose intolerance, orthopedic disorders, and psychosocial disorders. In addition, longitudinal studies show that overweight in childhood is associated with overweight in adulthood, which is a recognized health risk. Contributing factors to overweight include high body mass index of parents, low family income, high proportion of calories from fat, and long hours of watching television.

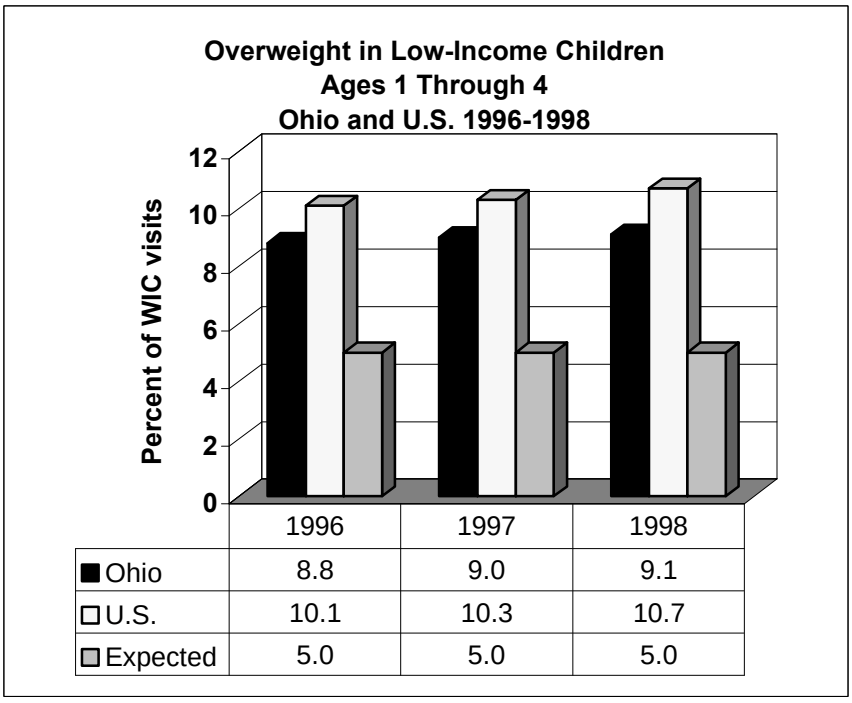
Quantitative Data In 1998, the prevalence of overweight for low-income children ages 1 through 4 in the WIC program was 9.1 percent. This rate is **lower** than the national rate of 10.7 percent. For Ohio and the nation, the data represent client visits, not individual children; therefore, the data are duplicated. There are no HP objectives targeted to overweight children under age 5. The expected prevalence of overweight

children younger than 5 years is 5 percent—less than half the actual prevalence. The Ohio rate in WIC clients ages 1 through 4 increased from 1996 (8.8 percent) through 1998.

Racial/Ethnic Disparities The racial/ethnic disparities in Ohio are similar to those of the nation. For children ages 0 through 1, the prevalence averaged over 1996 through 1998 in Ohio was highest among Hispanics (12.3 percent) and non-Hispanic Blacks (12.1 percent). The average prevalence was lowest among Asians and Pacific Islanders (9.9 percent). In the 2 through 4 year age group, overweight was highest among Hispanics (10.7 percent) and lowest among non-Hispanic Blacks (6.5 percent).

Age Trends In the 0 through 1 year age group, the prevalence averaged over 1996 through 1998 in Ohio approximated that of the nation (11.4 percent vs. 11.3 percent). In the 2 through 4 year age group, Ohio had a lower prevalence than the nation. (7.3 percent vs. 8.6 percent).

Geographic Disparities Ohio counties with a prevalence of overweight in WIC clients ages 1 through 4 that is much higher than the state average are Warren, Van Wert, Lawrence, Hardin, Jackson, and Highland. Counties with a much lower prevalence are Carroll, Clinton, Columbiana, Coshocton, Cuyahoga, Darke, Fairfield, Fulton, Gallia, Geauga, Guernsey, Harrison, Henry, Perry, Morgan, Noble, and Tuscarawas.



	1996	1997	1998
Ohio	8.8	9.0	9.1
U.S.	10.1	10.3	10.7
Expected	5.0	5.0	5.0

Anemia

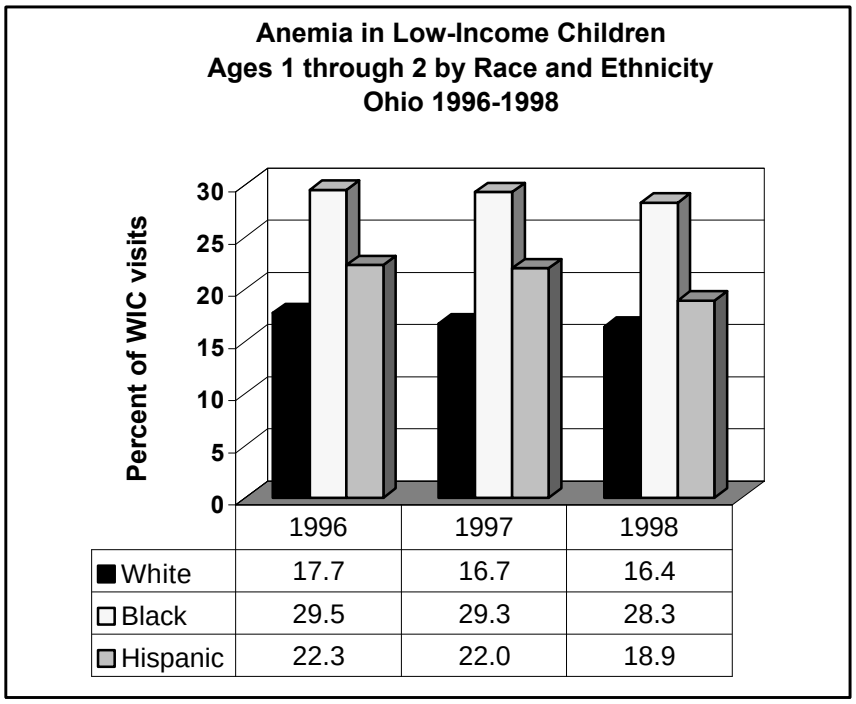
Description Anemia, defined by a low hemoglobin concentration or a low hematocrit level, is often used as an indicator of iron deficiency, the most common nutritional deficiency in the world. Iron deficiency is associated with developmental delays and behavioral disturbances in children. In addition to iron deficiency, anemia can be caused by other nutritional deficiencies (e.g., folate or vitamin B12 deficiency); hereditary defects in red blood cell production (e.g., thalassemia and sickle cell disease); recent or current infection; and chronic inflammation. Anemia is declining among low-income children as a result of increased iron intake during infancy; therefore, anemia is becoming less predictive of iron deficiency and more strongly associated with other underlying illnesses.

Quantitative Data In 1998, the prevalence of anemia for low-income children ages 1 through 4 in the WIC program was 18.5 percent. This rate is **higher** than the national rate of 17.2 percent. For Ohio and the nation, the data represent client visits, not individual children; therefore, the data are duplicated. The Ohio rate cannot be compared with the HP 2010 objective because that objective is based on measuring actual iron deficiency, not anemia. WIC measures anemia via hematocrit or hemoglobin tests. The Ohio rate in WIC clients ages 1 through 4 decreased from 1996 (20.3 percent) through 1998.

Racial Disparities The racial disparity in Ohio is similar to that of the nation. Anemia was highest in Blacks and lowest in Whites in 1998 in WIC clients ages 1 through 4.

Age Trends In Ohio and nationally, the rate of anemia averaged over 1996 through 1998 was higher in children ages 1 through 2 (20.7 percent), compared with children ages 3 through 4 (16.1 percent).

Geographic Disparities Ohio counties with a prevalence of anemia in WIC clients ages 1 through 4 that is much higher than the state average are Defiance, Hardin, Harrison, Perry, Richland, and Warren. Counties with a much lower prevalence are Belmont, Clermont, Erie, Highland, Knox, Lake, Madison, Portage, Washington, Wood, and Wyandot.



	1996	1997	1998
White	17.7	16.7	16.4
Black	29.5	29.3	28.3
Hispanic	22.3	22.0	18.9

C.7 Nutrition—Contributing Factors

Breastfeeding at Hospital Discharge

Description Breastfeeding is an important contributor to overall infant health, as human breast milk presents the most complete form of nutrition for infants.

Quantitative Data In 1998, the rate of breastfeeding at hospital discharge was 56.1 percent. This rate is **lower** than the national average of 64.3 percent. The Ohio rate increased from 1994 (48.9 percent) through 1998. The HP 2010 objective of 75 percent specifies "in the early postpartum period" rather than "at hospital discharge"; therefore, the Ohio rate cannot be directly compared with the HP target rate.

Racial/Ethnic Disparities White women and Hispanic women, with rates of 67.9 percent and 66.2 percent in 1998, were more likely to breastfeed than Black women, whose rate was 44.9 percent.

C.8 Oral Health—Morbidity

Dental Caries

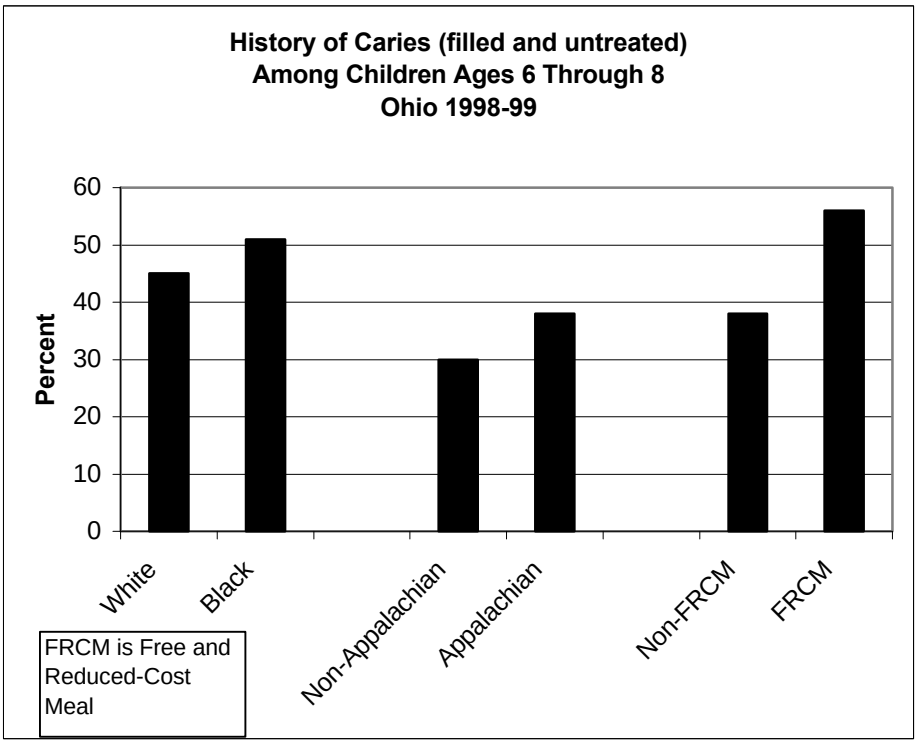
Description Dental caries is described by two measures—disease attack and untreated disease. This measure indicates the lifetime history of tooth decay, counting previously decayed (filled) teeth as well as currently decayed (untreated) teeth. This measure reflects the extent to which factors that cause decay (such as diet) balance against preventive factors (such as exposure to fluorides and sealants). Dental caries (tooth decay) is the most common infectious disease of U.S. children. Fifty-two percent of children ages 6 through 8 have been affected by dental caries. The percentage increases to 84 by the time children have graduated from high school. Unless arrested in the earliest stages, dental caries becomes irreversible, progressing to large cavities and abscesses.

Quantitative Data In a survey during the 1998–99 school year, 47 percent of children ages 6 through 8 had experienced dental caries. This rate is **lower** than the national rate of 52 percent for data from 1988 through 1994. The Ohio rate is **higher** than the HP 2000 target rate of 35 percent and the HP 2010 target rate of 42 percent. Ohio does not have data for each for the past five years. A survey conducted in school year 1992–93 revealed a prevalence of 50 percent.

Racial Disparities Black children had a higher rate than White children (51 percent vs. 45 percent).

Geographic Disparities The rate of dental caries for children from Appalachian counties was higher than for children in other counties (approximately 38 percent vs. 30 percent).

Socioeconomic Disparities Children participating in the free and reduced-cost school meal program were more likely to experience dental caries than children not eligible for the program (56 percent vs. 38 percent).



Untreated Dental Caries

Description: Untreated dental caries (tooth decay) can result in needless pain and suffering; difficulty speaking and chewing; increased cost of care; and loss of self-esteem. Dental caries afflicts more persons than any other single disease in the United States and is amenable to early intervention. In Ohio, 75 percent of tooth decay is found in only 17 percent of children.

Quantitative Data Based on a sample of more than 11,000 third graders, the percentage with untreated caries was 26 for the school year 1998–99. This rate is **higher** than the HP 2000 target rate of 20 percent untreated dental caries and the HP 2010 target rate of 21 percent. Both HP objectives are for ages 6 through 8. The rate decreased from the school year 1992–93 (31 percent) through the school year 1998–99.

Racial Disparities Black children have a slightly higher rate than White children (29 percent vs. 25 percent).

Geographic Disparities Approximately 35 percent of children in Appalachian counties have untreated dental caries vs. 21 to 22 percent in other areas.

Socioeconomic Disparities The most significant disparity exists between students who participate in the free and reduced-cost school meal program, and children not in the program (34 percent vs. 17 percent).

Participation in the free and reduced-cost meal program is used as a proxy for socioeconomic status (SES) and income.

C.9 Oral Health—Contributing Factors

Protective Sealants in Third-Grade Children

Description Dental sealants are the most effective method of preventing tooth decay in the surfaces that are most susceptible. Ohio has eliminated disparity in sealant prevalence—largely through school-based programs—among children who are 8 years old.

Quantitative Data In 1999, 34 percent of third graders in Ohio received protective sealants on at least one permanent molar tooth. This rate is **higher** than the national rate of 23 percent for 8-year-olds and **lower** than the HP 2000 target rate of 50 percent for 8-year-olds. The rate increased from 1993 (29 percent) through 1998. Ohio did not reach the goal of 50 percent of all third graders having dental sealants. However, 55 percent of high-risk third graders (those on the free or reduced-cost meal program)—regardless of race—in schools with dental sealant programs have dental sealants.

Ability to Get Wanted Dental Care

Description Many children do not receive dental care because their parents or caregivers do not seek care for them. Some of the barriers to dental care include the following: the perception that dental care is required only for a swollen face and painful tooth, inability to find a dentist who accepts Medicaid, lack of insurance, and cost. School nurses in Ohio's highest risk schools estimated that only 50 percent of the students referred for treatment received the needed dental care. They cited lack of money/insurance by the family to pay for dental care and the low priority of dental care by the family as barriers to treatment.

Quantitative Data In a survey during the school year 1998–99, 19 percent of the third-grade children whose parents wanted dental care for them in the preceding 12 months could not get it. There are no HP 2000 or HP 2010 objectives for this issue.

Racial Disparities Blacks were less likely to get the dental care they wanted than Whites (25 percent vs. 16.5 percent).

Geographic Disparities Parents in Appalachian counties were slightly more likely to report that their children could not get the dental care they wanted.

Socioeconomic Disparities Children on the free and reduced-cost meal program were four times more likely to be unable to get dental care than those not eligible for the program (29 percent vs. 7 percent).

Adolescent Tobacco Use

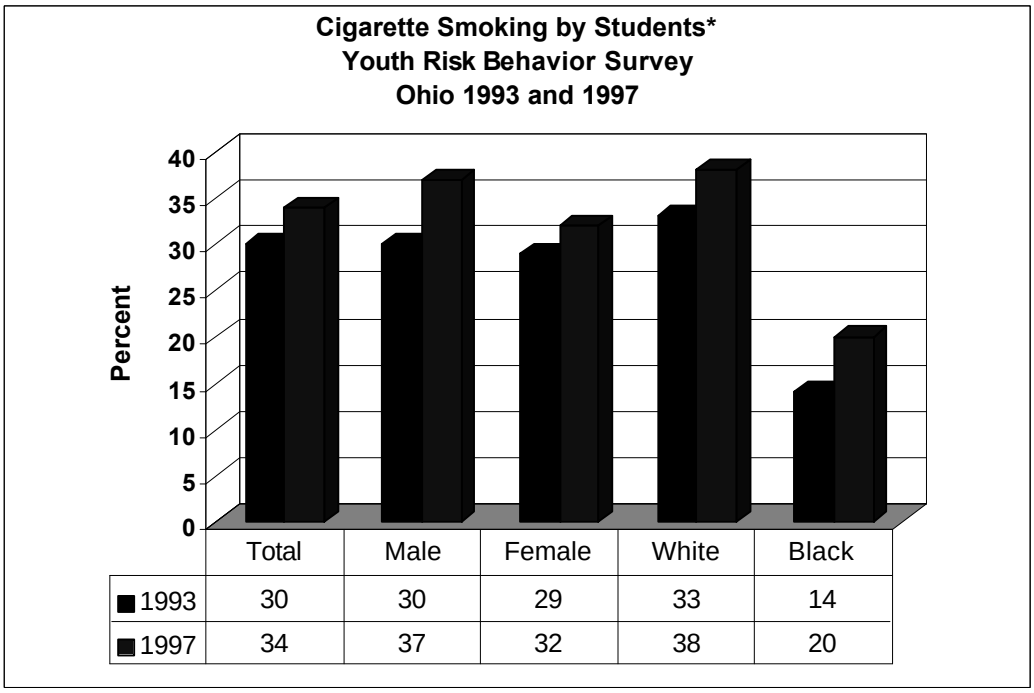
Description Tobacco use, both smoking and smokeless, is the chief preventable cause of death in the United States. It is responsible for approximately one of every five deaths. Smoking is related to poor academic performance and the use of alcohol and other drugs.

Quantitative Data The data for this health issue come from the YRBS. In 1997, 34 percent of students in grades 9 through 12 reported smoking one or more cigarettes on at least one of the 30 days preceding the survey. This rate is **lower** than the 1997 rate of 36.4 percent reported by the YRBS for the nation. The Ohio rate is **higher** than the HP 2010 target rate of 28 percent. The rate increased from 30 percent in the 1993 survey. Preliminary data from the 1999 survey indicate a rate of 40 percent. Smokeless tobacco products were used by 19 percent of teen males in 1997.

Racial Disparities In 1997, tobacco use was more prevalent in White teens than in Black teens (38 percent vs. 20 percent).

Gender Disparities In 1997, slightly more males than females smoked (37 percent vs. 32 percent).

Age Disparities In 1997, the percentage of teens who smoked increased steadily from ninth grade to twelfth grade (29 percent vs. 39 percent).



	Total	Male	Female	White	Black
1993	30	30	29	33	14
1997	34	37	32	38	20

*smoked one or more cigarettes within the 30 days preceding the survey

Adolescent Alcohol Use

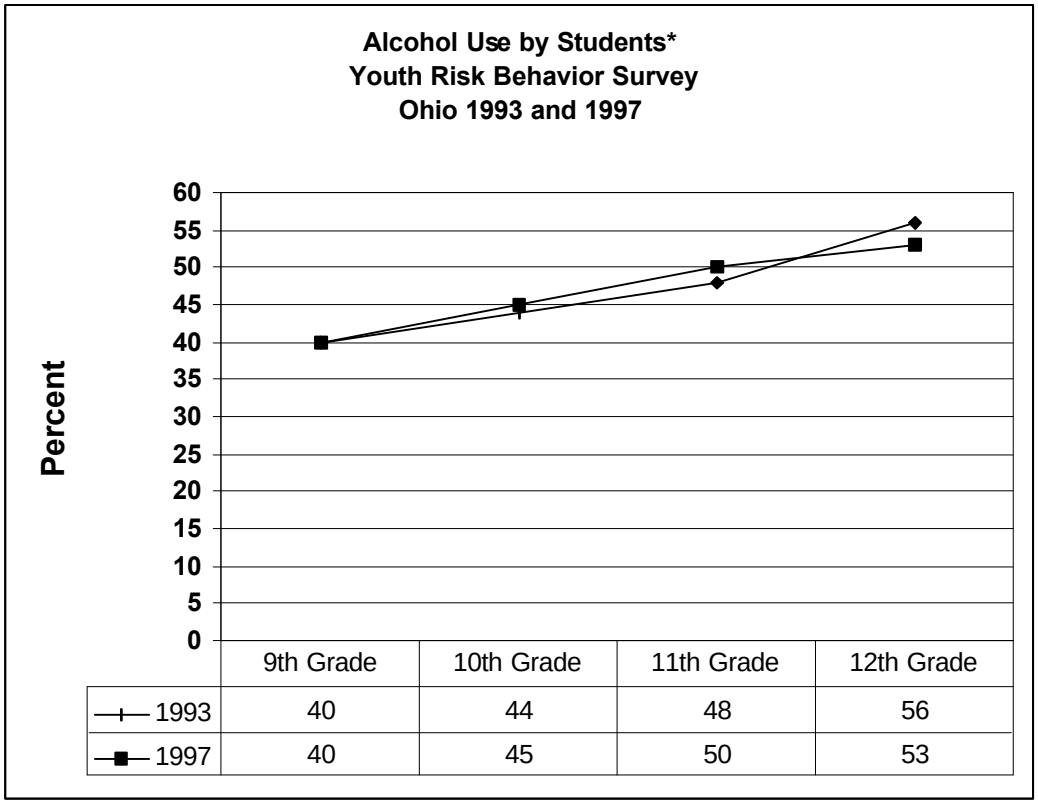
Description: Alcohol is a major contributing factor in approximately half of all homicides, suicides, and motor vehicle crashes; all of these are leading causes of death and disability among young people. Heavy drinking among youth has been linked to physical fights, destroyed property, academic and job problems, and trouble with law enforcement authorities.

Quantitative Data The data for this health issue come from the YRBS. In 1997, 46 percent of students in grades 9 through 12 reported having had at least one drink on one or more days of the 30 days preceding the survey. This rate is **lower** than the 1997 rate of 50.8 percent reported by the YRBS for the nation. The Ohio rate is **higher** than the HP 2010 target rate of 14.5 percent. The rate stayed relatively level from 1993 to 1997, but increased from 46 percent in 1997 to 56 percent in 1999.

Racial Disparities In 1997, alcohol use was more prevalent in White teens than in Black teens (48 percent vs. 36 percent). The rate for Blacks decreased from 48 percent in 1993.

Gender Disparities Slightly more males than females used alcohol in 1997 (48 percent vs. 44 percent).

Age Disparities The percentage of teens who used alcohol increased steadily from ninth grade to twelfth grade in 1997 (40 percent vs. 53 percent).



	9th Grade	10th Grade	11th Grade	12th Grade
1993	40	44	48	56
1997	40	45	50	53

*had one or more drinks within the 30 days preceding the survey

C.11 Vision—Morbidity

Referrals for Vision Treatment

Description Abnormal visual acuity is a common chronic medical condition in children of industrialized nations. Prevalence of abnormal vision findings in children ranges from 3 percent to as much as 25 percent. The need for early detection of vision disorders is widely recognized and stressed due to the irreversible effects of some undetected vision disorders.

Quantitative Data Data are cumulative because all children enrolled in Ohio schools are screened at each of the grade levels kindergarten, 1, 3, 5, 7, and 9. The percentage of children with vision screenings who require referral for treatment is 11. This is **lower** than the national percentage of 12.3. The HP 2000 objective is to reduce significant visual impairment to a prevalence of no more than 30 per 1,000 people. The HP 2010 objective is to reduce uncorrected visual impairment due to refractive error.

Age Trends Rates of vision referral for preschool children are significantly lower than for school-aged children (3 to 5 percent vs. 11 percent). Children ages 9 to 12 show a marked increase in referral due to increasing nearsightedness (myopia). The increase in myopia in elementary age children increases the overall state and national average.

Serious Eye Injuries in Children

Description Because eye injury can result in permanent partial or total loss of vision, preventive measures are good public health policy. Loss of vision creates an obvious barrier to education, future employment, and the quality of life.

Quantitative Data Ohio's voluntary injury reporting system maintained by the Ohio Ophthalmological Society reported 12 serious eye injuries to children in 1998. An average of 27 serious eye injuries per year was reported from 1994 through 1998. This number may not represent the true number of serious eye injuries because reporting is voluntary, and the interpretation of a serious eye injury is subjective.

C.12 Qualitative Data—Consumers and Key Informants

Below is a summary of perceived needs related to child and adolescent health status issues. Qualitative data related to health services issues are presented in Section 3.1.2.2/3.1.2.3.

- *Household Survey* respondents named these health issues as the most important problems for children: poor nutrition, drugs, child abuse, and obesity/eating problems. For adolescents, the issues most frequently reported were drug abuse, AIDS/other STIs, and teen pregnancy. Respondents also mentioned smoking, alcohol abuse, promiscuity/sexual activity, poor nutrition, obesity/eating problems, and mental illness.
- *Health commissioners* cited the following as the most important child health issues in their communities: oral health problems, nutrition-related conditions, child abuse, and immunizations.

- *Key policy makers* mentioned the following as top unmet health care needs for the state overall and/or their constituents: child abuse, teen sexual intercourse, health risk factors (alcohol/substance abuse, smoking, obesity), dental problems, homicide, and nutrition-related conditions (overweight, underweight, anemia, obesity as a result of an eating disorder).

A summary of the results of the community health assessments conducted by the CFHS Projects related to child and adolescent health status issues is presented in C.13 in this section.

C.13 Qualitative Data—Community-Identified Issues

Below is a summary of findings from the community health assessments conducted by the CFHS Projects. Qualitative data related to health services issues are presented in Sections 3.1.2.2/3.1.2.3.

- At least half or more of the counties identified teen births as their highest priority health issue related to children and adolescents.
- Between a quarter and half of the projects identified the following children's health issues as priorities they would address in their communities: immunization, lead screening, need for oral health care, overall child mortality, child mortality due to motor vehicle crashes, and low-income children who are overweight.

D. Children with Special Health Care Needs Health Status

The prevalence of CSHCN has been difficult to determine both in Ohio and nationally. The difficulty stems from the lack of a consistent, precise definition of who is or is not a child with a special health care need. Without this population-based denominator, therefore, the percentage of CSHCN who receive services through BCMH (Ohio's CSHCN program) has been impossible to estimate. Most of the data that were collected and issues that were discussed in Ohio's CSHCN needs assessment workshop related to health services (direct care and enabling) rather than to health status. The health services information on CSHCN is found in Section 3.1.2.2/3.1.2.3. The limited health status information on CSHCN follows.

D.1 Morbidity

Prevalence of Children with Special Health Care Needs (CSHCN)

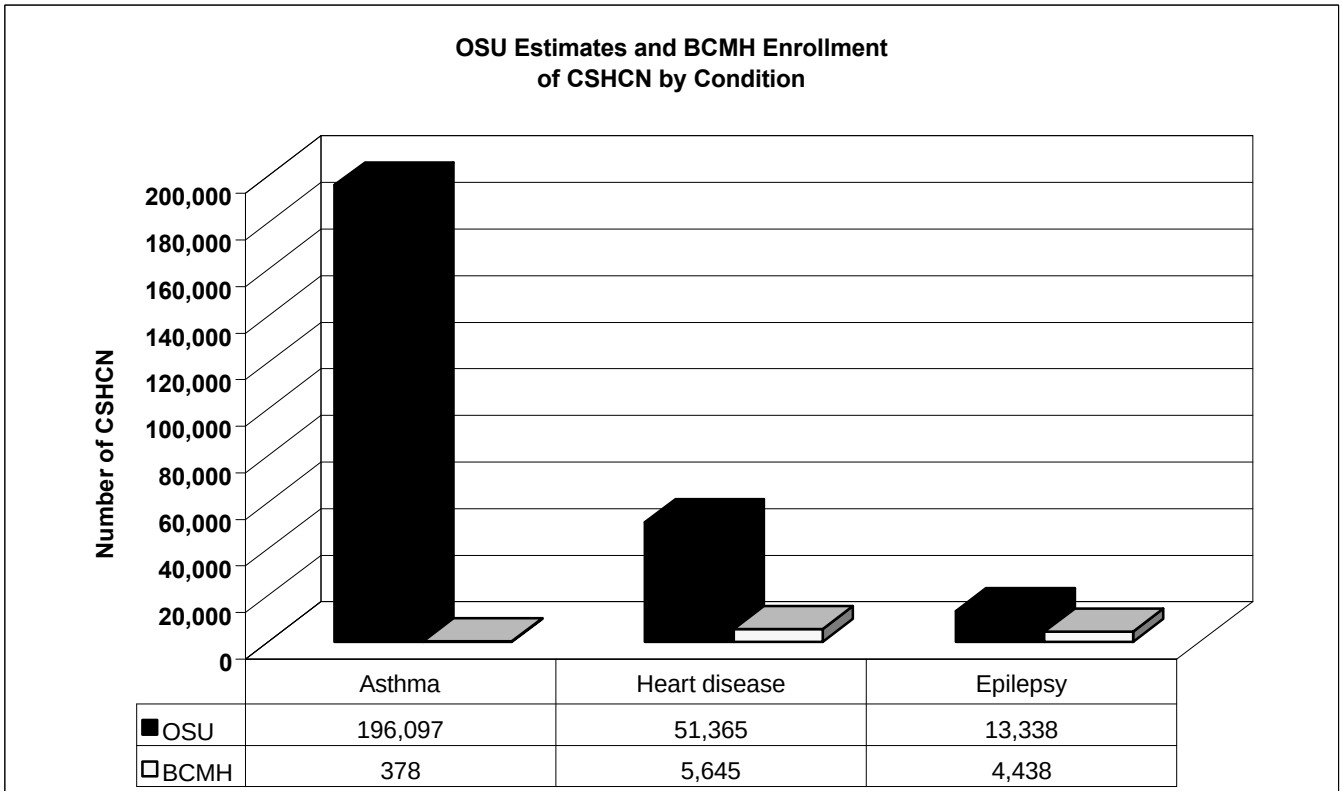
Description DFCHS recognizes the importance of overcoming past difficulties in determining the prevalence of CSHCN and in developing its capacity to collect population-based CSHCN data. In 1999, DFCHS used SSDI dollars to contract with the OSU School of Public Health to produce estimates of the number of CSHCN by condition. The University used data from the 1998 *Current Population Survey* of the U.S. Census and condition-specific incidence rates from the 1994 *National Health Interview Survey* (NHIS) *Disability Supplement.* This report is a first step in developing estimates of the number of CSHCN in Ohio and the percentage of CSHCN in Ohio who are served by the State Title V program.

Quantitative Data Estimates were generated for 18 conditions identified through the NHIS. These estimates are for children ages 0 through 17. The population data represent the 1997 estimates for Ohio.

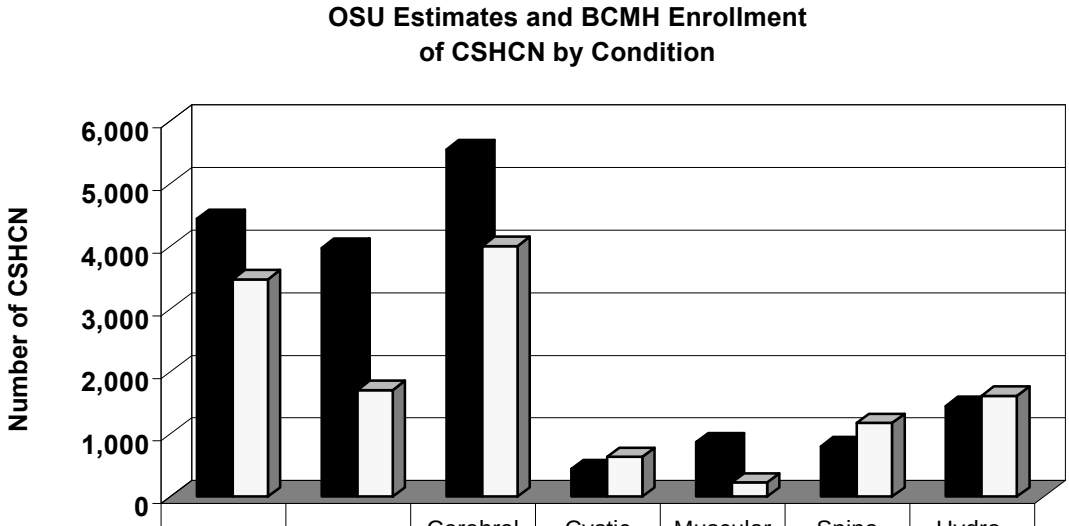
The data for each condition are not exclusive: children with more than one condition are listed for each condition that they have. The synthetic estimates and confidence intervals in parentheses for 11 conditions are listed below.

1. Cerebral palsy: 5,548 (4,119, 6,978)
2. Cystic fibrosis: 443 (0, 971)
3. Muscular dystrophy: 871 (360, 1,383)
4. Spina bifida: 803 (247, 1,359)
5. Autism: 2,483 (1,499, 3,468)
6. Down syndrome: 2,407 (1,472, 3,341)
7. Hydrocephalus: 1,447 (418, 2,476)
8. Diabetes: 3,973 (984, 6,962)
9. Heart disease: 51,365 (40,712, 62,019)
10. Epilepsy: 13,338 (7,911, 18,765)
11. Asthma: 196,097 (175,577, 216,617)

These estimates were then compared to the actual numbers of children with each condition enrolled in the BCMH CSHCN program. For those conditions for which BCMH has a comprehensive Team Program, such as cystic fibrosis and spina bifida, the synthetic estimates compare favorably to the actual BCMH numbers. In contrast, for those disorders for which BCMH does not have a comprehensive team approach, the synthetic estimates are much higher than the actual BCMH numbers. This is interpreted to show BCMH is not enrolling many of this population. This was most remarkable in regards to asthma and muscular dystrophy. This information will allow BCMH to target populations that are not presently being served. BCMH also requested data from the Special Education Section of the Ohio Department of Education.



These data showed a remarkable increase in the recognition of autism by the school systems in Ohio. At the present time, BCMH authorizes diagnostic evaluations for autism and relies on the school system for treatment. This is an area of demonstrated need in Ohio.



	Hearing	Diabetes	Cerebral Palsy	Cystic Fibrosis	Muscular Dystrophy	Spina Bifida	Hydro-cephaly
OSU	4,438	3,973	5,548	443	871	803	1,447
BCMH	3,474	1,705	4,005	634	230	1,179	1,611

Prevalence of Congenital Anomalies

Description Congenital anomalies are the leading cause of death in infants under 12 months of age. In Ohio, this translates to about 1,230 infant deaths each year.

Quantitative Data In 1998, 2,263 congenital anomalies were reported on birth certificates for a rate of 1.5 percent of all live births. The rate decreased overall from 1992 (2.3 percent) through 1998. However, the number of congenital anomalies is considered to be an underestimate due to detection of congenital anomalies after hospital discharge and to under-reporting prior to discharge. Over 6,000 Ohio infants are estimated to be born each year with congenital anomalies and genetic disorders. Of this number, CDC estimates that approximately 153 infants are born with neural tube defects, and approximately 242 infants are affected by fetal alcohol syndrome. (See Section 3.1.2.1 B.2. for information about incidence of neural tube defects.) About 1,529 infants are born with mental retardation each year; about 50 percent have a genetic basis for their disability.

D.2 Qualitative Data—Consumers and Key Informants

Most of the qualitative data related to CSHCN needs assessment pertain to health services (direct care and enabling) rather than to health status. A discussion of qualitative data related to health services is presented in Section 3.1.2.3 B.3.

- *Consumer focus groups composed of parents of children ages 0 to 3* mentioned asthma as an important health issue.

3.1.2.2. Direct Health Care Services

3.1.2.3 Enabling Services

The balance between the State's involvement in direct health care services and enabling services depends on the gaps that need to be filled. This can be a dynamic process that responds to changes in the economy (e.g., willingness of providers to treat Medicaid patients, health care benefits associated with employment) and public policy (e.g., Medicaid/SCHIP expansions, impact of managed care). Because the State's role in assuring access via enabling services is so closely linked to the availability of direct services, the two are considered together in this section. This section is structured as follows:

- The first part (A) examines the barriers that face the MCH and CSHCN populations and the systems or programs that seek to address those barriers.
- The second part (B) discusses CSHCN enabling services. While the issues for the maternal, infant, child, and adolescent population may be similar, those for CSHCN often have their own character.
- The third and final part (C) concludes with a list of priority concerns regarding access.

A. Barriers and Systems/Programs to Address Them

Most health care is provided by private providers and institutions. However, many Ohioans face barriers to accessing care in the private sector. Barriers can relate to *finances* (lack of financial resources, previous medical bills, deductibles, cost); *availability of providers* (distance to providers by miles and/or time, availability of transportation, availability of Medicaid providers); or *societal/acceptability issues* (language, poverty, cultural differences, discrimination).

A.1 Financial Barriers

Health Insurance Coverage

A major determinant of access to health care is the ability of a family to pay for care. Private and public health insurance are significant enabling factors. The 1998 Ohio Family Health Survey of over 16,000 households found 11 percent (1.3 million) of Ohio residents had no health insurance, similar to the 11.5 percent reported in 1990. Ten percent of children ages 0 through 17, or 284,400 children, had no insurance. This rate is **lower** than the national rate of 15 percent for this age group and **higher** than the HP 2010 target rate of 0 percent.

Racial, age, and economic disparities are apparent. The percentage of uninsured Black Ohioans ages 0 through 24 was 19.1 versus 13.5 of Whites and 6.2 of Asians in this age group. Ohioans in the 20 through 24 year age group were more likely to be without health insurance than younger groups (27.9 percent vs. 15 percent). Ohioans ages 0 through 24 who live in Appalachian and metropolitan counties were more likely to lack health insurance (17.0 percent and 15.5 percent) than their cohorts in suburban and rural non-Appalachian counties (9.5 percent and 10.8 percent).

Uninsured Ohioans reported several reasons for having no insurance. Affordability of coverage was most frequently cited (41 percent of respondents). Approximately one in five (21 percent) had no health insurance due to unemployment or changing jobs. Employers did not provide health insurance for one in seven who were uninsured. Among uninsured Ohioans living in poverty, 12 percent reported they either lost public assistance or were told they were ineligible for public assistance. About half (52 percent) of uninsured Ohioans of all ages and 38 percent of uninsured children were reported as having major medical costs, delaying or avoiding care, or having difficulty obtaining care. Thus, lack of insurance diminishes access to needed health services, including preventive and primary care, and tertiary and subspecialty care.

The Medicaid Program and SCHIP

Medicaid (including the expansion known in Ohio as Healthy Start) is the most significant source of payment for health care services for low-income Ohioans. As in other parts of the country, Ohio's Medicaid program has undergone major changes in the past five years. Today's Medicaid program also has been greatly influenced by the creation of SCHIP and the evolving role of managed care.

On January 1, 1998, Medicaid eligibility expanded to pregnant women and children at or below 150 percent of the federal poverty level. This is the Healthy Start eligibility category. For those meeting the SCHIP eligibility requirements, Ohio was able to take advantage of the enhanced federal match. This represented the first phase of Ohio's implementation of SCHIP. Since January 1998, 184,040 children have enrolled in the program. (When applied to the Medicaid program, the term *eligible* is equivalent to *enrolled.*) In SFY 2000, 123,865 children were eligible for the Healthy Start expansion and SCHIP programs. After 27 months of implementation (March 2000), the program was serving over 70,000 children, or 25 percent of the potentially eligible population. This included 64 percent of the uninsured and 10.8 percent of the insured potentially eligible.

The second phase of SCHIP expansion for children ages 0 through 18 at 151 to 200 percent of the federal poverty level will go into effect July 1, 2000. This is considered a Medicaid expansion for uninsured children, with Title XXI as the funding source. An annual premium of $25 per child, not to exceed $75 per family, is required. The number of children who will be covered in the first year is estimated to be 11,000.

Early in 2000, the Medicaid/SCHIP programs made the following improvements:

- Families who have income within 100 percent of the federal poverty level who choose to not receive cash or Food Stamp assistance will remain eligible for Medicaid as part of the Ohio Works First (Ohio's equivalent of TANF—Temporary Assistance for Needy Families) eligibility group.
- Eligibility will be established for 12 continuous months rather than the current 6-month period. If the child is eligible for 3 months retroactive to eligibility, then the eligibility period could be as long as 15 months.
- Simplification of eligibility will accompany the expansion. This includes: self declaration of age, identity, residence and citizenship; supplying the Social Security Number, but not having to show the SSN card; and no face-to-face interview requirement. These simplifications apply to all Medicaid participants, inclusive of the aged, blind, and disabled population.

Medicaid expansion has impacted the CSHCN program. Five years ago, BCMH anticipated that OhioCare, the proposed Medicaid expansion under Ohio's 1115 waiver, would free up direct service funding. Instead, that Medicaid expansion did not take place, and the program experienced a severe budget deficit. The program required a major expansion of state funding coupled with a reduction in its inpatient coverage.

When Medicaid expanded its Medicaid/Healthy Start coverage in 1998, BCMH took full advantage by requiring that eligibility be determined locally before the family applied to BCMH for treatment assistance. As the result, BCMH provider payments decreased from $27 million in SFY 1998 to $20 million in SFY 1999. This year, payments should decrease to slightly more than $18 million. Between 1996 and 1999, the number of children served by BCMH was reduced by slightly more than half. When the second phase of SCHIP begins in July 2000, BCMH anticipates that—with aggressive identification, outreach, and enrollment assistance on the part of public health nurses—the number of uninsured treatment recipients may be reduced again by half by July 2002.

Welfare Reform

Welfare reform has impacted Medicaid enrollment in Ohio. Between July 1997 and September 1999, the number of families eligible for Medicaid/Healthy Start dropped from 651,651 to 546,405, a decrease of 16 percent. Some families that lost their eligibility for cash assistance have become unnecessarily disconnected from Medicaid coverage because cash assistance and Medicaid eligibility were delinked under welfare reform. ODHS will be implementing activities to restore Medicaid coverage for those who lost it in error.

Medicaid Managed Care

Medicaid managed care operates in 16 counties, 4 of which are mandatory for Healthy Start eligibles. Those eligible through the aged, blind, and disabled categories remained on the fee-for-service program.

Welfare reform and a strong economy have most likely contributed to the significant decline in enrollment in managed care by persons who are eligible for Medicaid. In September 1999, enrollment was 252,902, a drop of 99,262, or 28 percent, from 352,164 in July 1997. Since the implementation of Medicaid managed care in 1996, three initially mandatory counties (Butler, Hamilton, and Montgomery) have reverted to voluntary status due to a significant reduction in the number of participating managed care plans in those counties. A critical repercussion of this return to fee-for-service status is the cessation of health care services by some primary care providers who previously rendered services under the Medicaid managed care plan.

Many CSHCN eligible through Healthy Start are required to enroll in Medicaid managed care plans. In the past two years, as the number of participating health plans has decreased, families have had to change plans and sometimes change physicians from the BCMH managing physician. Also, some children have had coverage by BCMH, a commercial managed care plan from the parent's employment, and Medicaid health plan. Families, with the assistance of the public health nurse (PHN), have had to deal with the different provider panels and separate authorization policies of each.

A.2 Lack of Availability of Providers

A lack of availability of health care resources, particularly for vulnerable populations, often results from geographic barriers and barriers within the very systems created to fill gaps (i.e., Medicaid). Although they have limitations, federally designated health professional shortage areas (HPSAs) are a proxy for summarizing the availability of mostly private providers. Safety net resources attempt to fill the gaps in the private system.

Data Sources and Limitations

Like other states, Ohio suffers from a shortage of primary care, dental care, and mental health care providers in a number of communities and counties. Attempts at enumerating shortage areas center on those that have gone through the process of being designated a federal HPSA. These data, however, do not present the whole picture because many areas that might qualify as HPSAs do not apply. In addition, limited ODH staff resources do not have the capacity to identify all areas that may meet the federal criteria for designation. While raw numbers of providers to population at the county level offer a gross indication of geographic shortage areas, they do not tell the story of communities, usually urban, in which poverty is concentrated in proximity to wealth. These areas may have a large number of providers, but a relatively small number serve the poor and near-poor populations. The true need in the State is therefore under-represented by the numbers that follow.

ODH has some data on advanced practice nurses and public health nutritionists by county. However, there are no standards against which to measure their availability. ODH does not have information on medical social workers, audiologists, occupational therapists, physical therapists, and speech-language therapists.

Primary Care HPSAs

Ohio has 66 Primary Care HPSAs. *See the Ohio Primary Care Shortages map in the Appendix.* They include much of rural Ohio and parts of every major city in Ohio (Cleveland, Cincinnati, Toledo, Columbus, Dayton, Youngstown, Akron and Canton). The map also shows the counties where Title V clinics (Well Child, Perinatal, Family Planning) and non-Title V clinics (federally qualified health centers [FQHCs], Title X Family Planning) are located. Note that the map does not include clinics at local health departments that are not funded by Title V or 330 funds. Although not identified to date, ODH plans to do so in future safety net analyses.

The counties with the largest metropolitan areas (Cuyahoga [Cleveland], Franklin [Columbus] and Hamilton [Cincinnati]) have many Primary Care HPSAs, but they also have many Title V and non-Title V Clinics to act as safety net providers. In the rural areas of Ohio, the safety net varies from none, in counties such as Paulding, Putnam, and Morrow, to significant, in counties such as Pike, Lawrence, and Ashtabula.

Dental HPSAs

As with Primary Care HPSAs, Dental HPSAs represent only those that have applied. *See the Ohio Dental Care Shortages map in the Appendix.* Other areas would likely qualify if they applied. The map illustrates the 26 Dental HPSAs, the dental care safety net programs, and the counties with the potential for shortage area designation. Ten more new Dental HPSA applications are in process at this time. The majority of Dental HPSAs have been identified for low-income population groups in both rural and urban areas. All of the geographic Dental HPSA designations in Ohio are for urban neighborhoods.

Mental Health HPSAs

The same caveats on using HPSA data as a proxy for shortage areas apply to mental health care providers. Ohio has eleven Mental Health HPSAs. *See the Ohio Mental Health Care Shortages map in the Appendix.* Four geographic designations indicate a need for 19 psychiatrists to serve a population of more than 287,000 Ohioans. Of the eight counties within these geographic designated areas, seven are in the Appalachian region. The remaining seven Mental Health HPSAs have been designated for facilities (five state prisons and two state psychiatric hospitals).

The Safety Net of Health Care Services

Even when people have Medicaid coverage, they still may have difficulty finding a private health care provider to serve them. Programs that serve as a safety net for vulnerable women and children are found in

a variety of settings (e.g., local health departments, community health centers, hospitals, and other community agencies). Some safety net programs receive funding through DFCHS, sometimes originating from Title V. The maps in the Appendix show the general locations of the larger systems of safety net providers for medical care (e.g., FQHCs, Title X, and CFHS) and dental care (all known safety nets, including hospitals and non-profits).

In Ohio, 14 organizations with 52 FQHC clinic sites in 22 counties receive federal 330 funds. For many pregnant women and children who are low income, eligible for Medicaid, and uninsured or underinsured, programs administered by DFCHS serve as an important part of the safety net by providing enabling services or direct health care services. The most notable systems are the CFHS Program, The Ohio Infant Mortality Reduction Initiative (OIMRI), specialty clinics, and dental care clinics. A description of each follows.

Child and Family Health Services Program (CFHS) is a community-based program that uses a combination of federal, state, and local monies to offer public health and safety net clinical services. These services include child and adolescent care, perinatal care, and family planning services. CFHS projects help families find and use services by providing outreach and case management; health education and referral; transportation; translation; home visiting; and nutrition counseling. Projects also provide support for community health assessment and planning, and monitor the status of vulnerable populations. CFHS projects, located in 81 of Ohio's 88 counties, provide services through 181 clinic sites. Of these, 132 sites operate child health clinics, 89 operate perinatal clinics, and 26 operate family planning clinics. The majority of counties without CFHS projects (6 of 7 counties) are located in the rural northwest region of the state.

The Ohio Infant Mortality Reduction Initiative (OIMRI) is a targeted perinatal service coordination program. It serves to conduct casefinding and recruitment of high-risk, low-income, pregnant, uninsured/underinsured women; to provide case management and care coordination; and to provide home visits on a regular basis during pregnancy and the baby's first year of life. Communities that are targeted have one or more of the following criteria:

An infant mortality rate that is at least twice the state rate

- A rate of low birth weight that is at least one and a half times the state rate
- A rate of very low birth weight that is at least one and a half times the state rate
- A prenatal population with a combination of high medical, behavioral, social, and economic risk factors
- A high percentage of Black and/or other ethnic and racial minority groups with high rates of infant mortality and low birth weight

Ten funded projects are located in metropolitan areas of the state. During FY 1999, 950 clients were followed, with 242 babies being born and 303 one-year-olds "graduating" from the program.

Pediatric Medical Specialty Clinics operate in 53 counties. The 500 clinics include these specialties: cardiac, developmental, hearing, neurology, orthopedic, plastic surgery, and vision. These services were established in response to the lack of medical specialists in rural areas. They support early identification and diagnosis of handicapping conditions as well as CSHCN. Children from ages 0 to 21 are eligible for services. Developmental clinics see children only from ages 0 to 6. One-half of all specialty clinic patients are age 8 or younger. Annually, 10,000 children receive diagnostic, treatment, and follow-up services from contracted specialists in the specialty clinics. Approximately 7,000 of the clinic visits are to the vision and hearing clinics. Physicians, school nurses, and health departments are the most frequent referral sources for these clinics.

Safety Net Primary Dental Care Clinics provide diagnostic, preventive, and treatment services primarily for people who cannot or will not access the private system, usually for reasons relating to payment. While the numbers often fluctuate, Ohio's 73 safety net primary dental care clinics currently include the following:

- 2 dental schools (plus 2 of their clinics for special populations);
- 18 city and county health department clinics;
- 20 hospital-based/linked programs;
- 12 FQHC clinics; and
- 22 other programs (e.g., United Way agencies, Community Action Agencies, homeless programs, church-affiliated and other volunteer programs).

Two-thirds of dental care safety net programs are in Ohio's eight most populous counties. The capacity of safety net dental clinics, in terms of the services they provide and the populations they serve, varies widely. Approximately one-third of the safety net clinics in the state saw an estimated three-fourths of safety net dental patients in 1999. The largest programs tend to be dental schools or hospitals, where Medicaid is accepted, but sliding fee schedules are rare. About half of safety net dental care programs have waiting lists to get initial appointments. Waits are typically one to three months, but some exceed six months.

School-based dental sealant programs serve 32 counties and over 25,000 children each year. Of the State's 17 programs, 15 receive Title V funds from ODH. Sealant programs reach more than half of the State's high-risk elementary schools. ODH also combines Title V and state dollars to fund the OPTIONS program of referral coordinators (case managers) linking low-income and/or disabled individuals with dentists willing to provide discounted or donated care.

A.3 Qualitative Data on Health Services—Consumers and Key Informants (Related to Maternal, Infant, Child, and Adolescent Issues)

In addition to health status issues, health services issues were frequently mentioned by participants in interviews, surveys, and focus groups. Below is a summary of perceived needs to maternal, infant, child, and adolescent health services issues.

- *Household Survey* respondents named these health services issues as the most important health problems facing children: lack of quality health care, lack of health insurance, lack of regular check-ups, and lack of health education.
- *Consumer focus groups composed of parents of children ages 0 to 3* responded that these were important health services issues: insurance, access to providers/specialists, dental care, prescriptions, and mental health care. They cited limits on insurance coverage and reluctance of doctors and dentists to accept Medicaid as problems. They also had experienced difficulty accessing health care because of difficulties in coordinating transportation, long delays to get appointments, and doctors who do not speak English. Some stated that prescriptions should be covered by insurance.
- *Consumer focus groups composed of parents of children ages 3 to 14* voiced many of the same concerns as the above focus groups. They mentioned these as important health services issues: access to providers/specialists who accept Medicaid, dental care, vision care, and prescriptions. Dental care led the list of services that parents had trouble accessing. The major reason was affordability, including the reluctance of dentists to accept Medicaid. Other services with which parents had difficulty were finding physicians who would accept Medicaid, specialists, vision care, prescriptions, and hearing tests. Again, affordability was the primary reason for problems with accessibility. Parents in the Appalachian counties reported that they faced transportation problems, difficulty getting prescriptions, and cultural problems when they went to urban areas for assistance.
- *Health commissioners* cited these health services issues as important problems in their communities: lack of providers/services (e.g., family planning), lack of dental care, prescriptions, transportation, cultural issues, immunizations, lack of health insurance, lack of parenting skills, accessibility/availability, and availability of state resources.
- *Key policy makers* mentioned the following as top unmet health service needs for the state overall and/or their constituents: access to care (insurance issues), access to dental care, and health and safety of children in child care.

B. Direct Care and Enabling Services for CSHCN

B.1 Coordination of the CSHCN Program

The State CSHCN program, coordinated by BMCH, has gradually shifted the mixture of services provided from funding of direct health care to enabling services.

Public health nurses and the following individuals coordinate enabling services. The *Medical Review Nurses* stationed in the Columbus office of BCMH are responsible for case management. These people communicate with the BCMH Field Nursing Consultant, medical center staff, the child's family, the physician, and the PHN. The *specialty team service coordinator* is usually a clinical nurse specialist or social worker located in the tertiary medical center. The child's *managing physician* is responsible for developing a medical treatment plan, coordinating the request of services needed by the child, and submitting the necessary reports to BCMH. BCMH has been transitioning reimbursement for local public health nursing services from a flat rate per home visit to a more inclusive method. This method takes into account all the supportive activities conducted by PHNs who are the community-based support for families in the coordination of medical and supportive services. The change in reimbursement, while necessary, has not been sufficient to assure that families in all local health districts have equal access to the assistance of a PHN.

Families require varying degrees of assistance in negotiating the increasingly complex systems of care and assistance (both public and private). For some, the help should come from another parent. For others, the PHN or a service coordinator from Early Intervention is appropriate. Some families are self-sufficient and need no outside help in coordinating their child's services, provided that the systems furnish sufficient information on what services are available and how to access them. Many families need special assistance in negotiating the county department of human services system and support in completing the Medicaid application process—and indeed, in reapplying. PHNs have been especially helpful in educating families about what they need to do and, at times, advocating on their behalf with human services agencies.

B.2 Systems Issues

Serving Children on Supplemental Security Income (SSI) Children who receive SSI have some disabling condition and live in families with modest incomes. Disabling conditions are more likely to be mental (65 percent) than physical, although children may have secondary medical problems. The predominant disabling condition is mental retardation (37 percent), followed by diseases of the nervous system and sense organs (12 percent).

BCMH annually serves, through its treatment program, approximately 9 percent of children in Ohio who receive SSI and are under age 16 (1,872 of 20,286). Because the method of calculating the number of children on SSI served by BCMH changed, no data exist as to whether this number has increased or decreased. The number of active BCMH treatment cases also on SSI was estimated by matching BCMH files with Medicaid Management Information System files from ODHS to determine the number of children on BCMH receiving Medicaid for the Disabled. In Ohio, recipients of SSI are not automatically eligible for Medicaid.

Uninsured CSHCN Served by Title V Nearly 11 percent of the children enrolled on the BCMH treatment program in SFY 1999 had no other source of health care coverage for the entire year; partial year coverage was not captured. Counties having the highest numbers of uninsured children receiving BCMH treatment services are, in rank order, Geauga, Franklin, Hamilton, Holmes, Cuyahoga, Trumbull, and Summit. Between SFY 1996 and 1999, the number of uninsured children enrolled for BCMH treatment services decreased from 3,983 to 1,763, a decrease of 55.7 percent. When eligibility for Healthy Start/SCHIP expanded in January 1998, BCMH began to require that eligibility for these programs be established prior to eligibility for BCMH treatment. The number of uninsured BCMH treatment recipients should continue to decrease with the implementation of the second phase of SCHIP in July 2000. This needs to be closely monitored, however, because some states have started to show an increase in the number eligible for Medicaid.

Medical Home Each child with a special health care need should have an identifiable medical home. According to the American Academy of Pediatrics (AAP), a medical home has the following components: accessible care, family-centered care, continuing care, comprehensive care, coordinated care, compassionate care, and culturally competent care. In addition, the managing physician of a medical home is a trusted, well-trained pediatrician or other physician who can manage and facilitate all aspects of pediatric care. An HP 2010 objective is to increase the proportion of persons who have a specific source of ongoing care. State baseline data against which improvement can be measured are not yet available. However, ODH is working with the Ohio Chapter of the AAP to develop a network of medical homes for CSHCN.

BCMH addressed one of the components of the definition of a medical home—accessible care. Whether measuring other aspects of the medical home as defined by the AAP is feasible will be determined. In 2000, BCMH surveyed a sample of the families it serves to estimate the percentage of CSHCN who had a medical home and to learn about the quality of care. Of 590 surveys, 307 (52 percent) were returned. Almost all (294 families or 96 percent) responded that their child had a regular doctor or clinic for routine health care. The majority of these (83 percent) had been going to the same provider for at least one year; most (70 percent) had seen the same provider for at least three years. Nearly all of the respondents (95 percent) were able to get an appointment with the doctor or clinic within one to two days. Many (95 percent) indicated that the doctor or clinic answered all their questions regarding their child's health in ways that were clear and easy to understand always or most of the time.

Family Participation in the CSHCN Program BCMH is committed to being accountable to the customers of its services. In the past five years, BCMH has increased consumer participation significantly through the appointment of a full-time Parent Consultant. The Parent Consultant is involved in key

workgroups and in establishing a Parent Advisory Council. Parent focus groups conducted as part of this needs assessment will serve as the basis for a continuing dialogue with families in their communities.

The focus groups pointed out the need for families to feel that they have meaningful input into the programs that serve them or that those programs are responsive to their expressed needs. While BCMH has made significant progress in increasing family participation, the Bureau recognizes that it needs to continue improvement in its relationship with families. Currently, BCMH does not conduct customer satisfaction surveys, does not measure the impact of policy and procedure changes on families, and does not ask individual families what services they need that neither BCMH nor any other program supplies. These are areas BCMH has identified in need of improvement.

Genetic Evaluation and Counseling Services In 1999, ODH established the Regional Comprehensive Genetic Center (RCGC) electronic database. Aggregated data are available for previous years. All RCGCs funded by ODH are required to submit data on all individuals (without identifiers) they serve as well as data on all education activities they conduct. Other ODH systems that collect data related to genetics include the following: electronic birth certificates, which include data collection of some specific birth defects; The Behavioral Risk Factor Surveillance System, which asks women of childbearing age what they know about the use of folic acid and the prevention of neural tube defects; and The Pregnancy Risk Assessment Monitoring System (PRAMS), which collects data on what women of childbearing age know about the following: the use of folic acid and the prevention of NTDs, history of birth defects in women of childbearing age, and alcohol use by pregnant women.

B.3 Qualitative Data on Health Services—Consumers and Key Informants (Related to CSHCN)

Below is a summary of perceived needs related to CSHCN health services issues.

- *Focus groups composed of the families of CSHCN* reported the following health services issues as problematic: gaps in services, service coordination, information, and systems barriers. See *Family Participation in the CSHCN Program* and *Medical Home* under B.2 in this section for results of focus groups related to those issues.
    1. These are some of the *major gaps in service* reported by parents: therapies (such as speech and physical); specialized medical equipment (such as adaptive play equipment, air cleaners, specialized clothing); mental health services for the entire family; transportation (especially for those in rural areas); and medical home. Parents also cited not having a provider in one's locale for needed services; not having a provider who will accept one's insurance coverage; and not having a way to pay for the services.
    2. Regarding *service coordination*, families stated that they would like to know where and whom to call for help. They wanted information and help in accessing services, but they did

not want to be controlled. Parents complained that many service providers were coming into their homes but were not helping them to coordinate the services they needed.

3. The *need for information* was repeatedly mentioned. Most parents stated that their primary source of information about health care was word of mouth from other parents. Parents recommended the publication of a resource book of available services.
4. Participants reported these *systems barriers:* too much paperwork, difficulty in understanding the application processes, and delays and denials due to paperwork.

- *Health commissioners* named many health service issues for the maternal and health population that also apply to CSHCN. See A.3 in this section.
- *Key policy makers* named gaps in payment sources for needed services (no insurance or insufficient insurance) as the major issue for CSHCN. They also mentioned these top unmet health care needs of CSHCN: access to care (insurance issues, providers not taking patients on Medicaid, not enough providers); insufficient services for some conditions (such as mental health and autism); availability of information on health resources and eligibility for programs; and coordination of services. Key policy makers also stated that public programs require too much paperwork to determine assistance.

C. Priority Access Concerns

The State has identified the following concerns regarding access to health care and health-related services. The needs assessment process incorporated data required to measure the MCH Block Grant performance and outcome measures, and the health status indicators that were being developed by the federal MCH Bureau. These are organized by the four levels of the pyramid.

C.1 Concerns for the Maternal and Infant Population

For all of the following, the concern relates to deficits in the specified item.

Direct Health Care Services

1. Access for low-income women to high-risk perinatal and family planning safety net services

Enabling Services

1. Assistance in the enrollment process for available health insurance plans
2. Targeted outreach efforts to bring high-risk women into early prenatal care
3. Culturally appropriate family planning materials
4. Prenatal smoking cessation programs
5. Programs that employ community health workers to improve access to care through culturally competent care coordination

Population-Based Services

1. Awareness of the public about reproductive health and family planning services
2. Awareness among low-income women about the importance of early and continual prenatal care

3. Understanding among pregnant women of the harmful effects on the fetus from smoking during pregnancy

Infrastructure Building Services

1. Information and training for providers on the following:
   - Breastfeeding
   - Factors contributing to low and very low birth weight
   - Culturally competent practices
   - Identifying populations at risk for poor birth outcomes
   - Domestic violence
2. Quality data and information for policy development and program planning on the following:
   - Smoking among pregnant women
   - Access to early prenatal care
   - Adequacy of prenatal care
   - Effective outreach strategies
   - Education needs of prenatal providers
   - Availability of high-risk prenatal services
   - Low and very low birth weight factors and trends
   - Rates of breastfeeding
3. A plan for a statewide system for infant, child, and adolescent death review
4. Information for legislators, policymakers, and MCH stakeholders on risk factors contributing to low birth weight and the effect of prenatal care on birth outcomes
5. Understanding among prenatal service providers of the barriers to care that pregnant women face

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C.2 Concerns for the Child and Adolescent Population

Direct Health Care Services

1. Access for low-income children and adolescents to dental care (including dental sealants)
2. Adolescent and family planning safety net services
3. Providers accepting Medicaid

Enabling Services

1. Assistance in the enrollment process for available health insurance plans
2. Effective community-based outreach and enrollment strategies to ensure that children receive needed health care services through Medicaid/SCHIP

Population-Based Services

1. Public awareness about the following:

- Overweight children and healthy eating and exercise
- Community-based fluoride promotion
- Health effects of childhood lead poisoning
- Importance of oral health and issues relating to access to dental care
- Importance of early professional vision care for children
- Importance of immunization schedule
- Postponement of teen sexual activity
- Proper use of safety devices to decrease motor vehicle deaths in children
- Navigate of the health care system
- Adolescent asset building models
- Risk factors for adolescent suicide

2. Educational materials on immunizations that are low literacy and culturally sensitive

Infrastructure Building Services

1. Information and training for providers on the following:

- Pediatric obesity
- Oral health status, oral health resources, and access to dental care
- Blood lead screening policy
- Vision assessment
- Screening and referral
- Immunization schedule
- Adolescent risk assessment inventories
- Adolescent skill building and decision making models
- Promotion of motor vehicle safety
- Healthy Start/SCHIP information
- Risk factors for adolescent suicide
- Suicide prevention initiatives

2. Capacity among local public health agencies to conduct a community health assessment and planning process
3. A plan for a statewide system for infant, child, and adolescent death review
4. Quality data and information for policy development and program planning on the following:

- Childhood lead poisoning prevention
- Effective immunization outreach strategies
- Contributing factors for teen pregnancy and low birth weight
- Motor vehicle crashes
- Rate of uninsured children served through safety net health care programs

- Medicaid provider recruitment, training, and reimbursement
- Uninsured rates for children
- Medicaid eligible children receiving services
- Barriers to Medicaid enrollment

5. Coordination/collaboration with ODHS regarding blood lead screening for Medicaid eligible children
6. Collaboration among public and private agencies to coordinate immunization planning efforts
7. Information for legislators, policy makers, and MCH stakeholders regarding contributing factors related to teen birth rates

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C.3 Concerns for the CSHCN Population

Direct Health Care Services

1. Health care services—direct funding of those portions that are not covered by other funding sources. These services include physical, occupational, speech, behavioral, art, music, equestrian, and aquatic therapies.
2. Special equipment (educational, medical, and adaptive) and medical supplies. Parents need to be trained to use medical devices and equipment, and trained with educational material to help the child's development.
3. Home health care
4. Mental health services
5. Respite care
6. Specialized daycare. This is needed particularly for children with behavioral needs.
7. Nutrition services. These include evaluation, education, and supplements.
8. Medical homes. Concerns about respectful and caring treatment by primary and specialty care physicians should be incorporated in the strategy for assuring a medical home for CSHCN.

Enabling Services

1. Information. Families want more and better information regarding available services, eligibility requirements, particular conditions, and latest medical developments.
2. Assistance with navigating benefits systems. Families want help with the following: getting on the Medicaid waiver program; intervention with an insurance carrier to get a service approved or to request an out-of-network provider; requesting benefit exceptions; determining which payment source should cover a particular medical bill; and helping a family understand a denial and whether the denial should be reconsidered.
3. Distance to specialty care. This is a special concern for Appalachian families.

Infrastructure Building Services

1. Coordination among complex government programs. Families must deal with redundant eligibility processes, complex requirements, and high reading levels of materials.
2. Access to providers. Many providers will not accept the Medicaid card, particularly dentists, therapists in rural areas, optical providers, and pharmacies in some areas.
3. Continuity of care with the child's established provider. Continuity of care is either difficult or not possible when multiple sources are involved.
4. Establishment of a network of providers in both urban and rural areas who are needed to diagnose and treat asthma and PDD (Pervasive Developmental Disorder). These are two qualitatively different problems. Because these problems have both primary and specialty care components and cross the boundaries of different state agencies, the strategy is essentially that of infrastructure development through collaboration. Provision of direct and enabling services may be necessary to some extent to support infrastructure changes.
5. Availability of community PHN services. This is uneven across the state.
6. Comprehensive population-based data on CSHCN. Data is needed on the numbers and types of CSHCN, the extent to which their care needs are being met, and what public systems of care serve them.

3.1.2.4 Population-Based Services

Population-based services for the MCH population center on screening, immunization, community water fluoridation, and outreach/education.

A. Screening

Blood Lead Levels The numbers of children ages 6 months to 6 years screened for elevated blood levels were: 104,461 in 1996, 105,495 in 1997, and 119,553 in 1998. The rate of screening has increased 9 percent over three years.

Vision All children enrolled in Ohio schools are screened for abnormal visual acuity at each of the following grade levels: kindergarten, 1, 3, 5, 7, and 9. The vision screening rate in Ohio is approximately 88 percent. The rate of vision screening was 74 percent in the school year 1992–93, 83 percent for 1994–95, and 82 percent for 1996–97. The school year 1997–98 survey reported that 979,182 children were screened, which is 5.8 percent above the average for the five survey years. However, approximately 117,501 school children who should be screened are not screened. Based upon an 11 percent referral rate, 12,925 children need referral for treatment but are not getting it.

Hearing The Ohio Revised Code mandates that all newborns in hospital nurseries be assessed for risk for hearing loss and referred for hearing testing when identified with risk factors. Newborns are assessed by

means of a questionnaire developed by ODH. Approximately ten hospitals in Ohio have implemented universal newborn hearing screening. During 1998, 24,643 newborns (16 percent of births) received hearing screenings before hospital discharge or within the first two months of life. Currently, the results of hearing screenings are reported to ODH from hospitals by mailing the hard copy reports. ODH has identified and begun to address concerns associated with infant hearing screening. A data collection and tracking system currently does not exist for infants who are deaf or hard of hearing. A combined newborn data system will be implemented in 2000. This system will allow for a comparison of the number of births and the number of infants screened.

B. Population-Based Preventive Services

Immunization Coverage Through Age 2 In Ohio, children entering regulated child day care centers, Head Start, or kindergarten are required to be fully immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. Students must have a second MMR vaccine before entering seventh grade. Head Start also requires immunization against hepatitis B and Hib. Beginning in the fall of 2000, children entering kindergarten must receive hepatitis B immunizations. In 1998, 77.2 percent of children completed the recommended series of childhood immunizations for ages 19 through 35 months. This rate is **lower** than the HP 2000 target rate of 90 percent. The rate increased overall from 1995 (66.2 percent) through 1998. Immunization rates for the past two years have stayed about the same for all immunizations except varicella.

In 1998, a higher percentage of White children received all immunizations required at 35 months of age than Black children (83.7 vs. 78.9). However, the gap is closing: in 1995, 82.9 percent of Whites vs. 69.3 percent of Blacks received all immunizations. In 1999, a higher proportion of children in urban areas received immunization coverage required at 35 months of age than children in rural areas (87.1 percent vs. 79.2 percent). This gap is widening: in 1995, the percentages were 82.4 in urban areas and 81.0 in rural areas.

Community Water Fluoridation Thanks to a 1969 fluoridation law, 90 percent of Ohioans on community water systems receive optimally fluoridated water. Efforts to bring fluoridated water to the remaining 10 percent are ongoing, but successes are relatively few and far between.

C. Community Outreach/Education

Help Me Grow Since its inception in 1995, the Help Me Grow program has developed as Ohio's communication umbrella for many wellness programs. Help Me Grow increases public awareness about important issues such as prenatal and well baby care, early child development, child seat safety, lead poison prevention, child abuse prevention, and foster care and adoption opportunities.

Car Seat Safety DFCHS collaborates with the Division of Prevention on car seat safety interventions. They exchange information on new recommendations, standards of practice, and press releases from the Consumer Product Safety Commission with appropriate BCFHS staff; facilitate local collaboration among DFCHS funded agencies; participate in Ohio Safe Kids car seat safety events; and provide technical assistance to DFCHS funded agencies that provide child passenger safety activities.

SCHIP Outreach DFCHS collaborated with ODHS in several workgroups to promote access to Healthy Start/SCHIP. Population-based strategies included the following: statewide mailings to consumers about enrollment in Healthy Start/SCHIP; a Healthy Start/SCHIP advertisement in Help Me Grow Wellness guide; placement of enrollment information in local newsletters/newspapers; assistance to ODHS in development of a statewide Healthy Start/SCHIP logo and media campaign; and support to local projects funded by DFCHS to become involved in community-wide TANF outreach efforts to enroll children into Healthy Start/SCHIP and assure that children are receiving needed services.

3.1.2.5 Infrastructure Building Services

Infrastructure building services, the base of the MCH pyramid, are largely the assessment and policy development core functions identified by the Institute of Medicine in 1988. These functions are built on coordination and collaboration at all levels of government, and with the private and not-for-profit sectors.

A. Community Assessment and Planning

CFHS Program Plan Through its FY 2000 application process for CFHS grants, BCFHS stimulated local partnerships to conduct community needs assessment and planning. The amount of each CFHS program award was influenced by the applicant's community health assessment and planning process based on the nine-step *Ohio's Public Health Plan* model. Each applicant agency was required to describe how it would measure the effectiveness of the programs and services funded with the grant award. To support and empower local agencies in each of the steps of the community health assessment and planning process, BCFHS provided two one-day regional training sessions. Technical assistance also was provided to those agencies requesting additional assistance.

Oral Health Survey In 1999, the Bureau of Oral Health Services (BOHS) conducted a county-level oral health survey that—for the first time—made oral health status and access data available to local planners. In collaboration with CDC and the Association of State and Territorial Dental Directors, BOHS led the development of a model on conducting local surveys. This model will be used to train interested communities in Ohio. To monitor Title V performance measures annually, BOHS instituted a survey of the 25 sentinel schools that were found to be highly representative of the 336 Ohio elementary schools selected for the county-specific survey.

B. Coordination and Collaborative Relationships

Coordination of State Activities with Programs Implemented Under Title V and Related Federal Grant Programs DFCHS is responsible for the administration of the following closely related programs: (l) BCFHS administers the CDC Childhood Lead Poisoning Prevention Program; the Title X program; and services for women of childbearing age, infants, and children, particularly those who are low income or lack access to health care.

(2) The Bureau of Community Health Services and Systems Development (BCHSSD) administers the Primary Care and Rural Health Services Section, which identifies underserved areas of the state and attempts to place health care practitioners in those areas; the AIDS Client Resources Section, which provides funding for health care and support systems to the community from the Ryan White Care Act; adolescent health school-based clinics; the Abstinence Only Education Program; the Black Lung Program; and school health. (3) BCMH administers diagnostic, treatment, and service coordination services for CSHCN. (4) BEIS administers the Early Intervention Program for infants and toddlers; the State's genetic, sickle cell, and hemophilia programs; Welcome Home newborn visitation program; and the Ohio Early Start Program. (5) The Bureau of Nutrition Services (BNS) administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); and the Farmers Market Nutrition Program. (6) BOHS develops and implements programs to prevent oral diseases and to improve access to primary dental care for underserved Ohioans.

Title V and Title XIX Intergovernmental Collaboration The interagency agreement between ODH Title V and ODHS Title XIX is effective from July 1, 1999 and will remain in effect until June 30, 2001. This agreement is updated every two years. The DFCHS Medical Director sits on the Medicaid Medical Advisory committee and Executive Committee. The BCMH Bureau Chief and staff meet quarterly with the Medicaid Bureau of Consumer Support to resolve issues of mutual concern. The BOHS Chief routinely sits on ODHS ad hoc committees on dental Medicaid issues.

Other Intergovernmental Collaboration DFCHS has developed agreements and cooperative arrangements with many State agencies, including the Departments of Mental Retardation and Developmental Disabilities, Alcohol and Drug Addiction Services, Rehabilitation and Corrections, Human Services, Youth Services, and Education. DFCHS also has forged links with the University Affiliated Programs, the Cincinnati Center for Developmental Disorders (CCDD) and the Nisonger Center. CCDD and the Nisonger Center also house the MCH Bureau funded (Title V) Interdisciplinary Leadership Education Excellence in caring for Children with Neurodevelopmental and Related Disabilities training programs, which have close ties to DFCHS.

Intergovernmental and Interorganizational Collaboration The Ohio Family and Children First Initiative is a partnership among the State's social service, education, and health systems. The goal is to ensure that all children enter school ready to learn. This partnership is critical because no single system has the resources or capacity to meet this goal alone. The Family and Children First Cabinet Council provides oversight of the Initiative. Members of the Cabinet Council include the State Superintendent of Schools, and the Directors of the Departments of Alcohol and Drug Addiction Services, Mental Retardation and Developmental Disabilities, Budget and Management, Human Services, Youth Services, Mental Health, Aging, and Health.

Collaboration with the Medical Community and Social Service Organizations DFCHS programs provide many opportunities for collaboration and coordination with major providers of health and health-related services. Examples of collaborations include the following: working with the Ohio Chapter of the AAP to develop a pilot medical home program for CSHCN, working with the ACOG to assure that pregnant women have early and adequate prenatal care, working with the American Cancer Society on its Fresh Start Smoking Cessation Program for CFHS prenatal programs, and convening a Parent Advisory Committee for CSHCN. MCH Block Grant funds support regional perinatal teams that are housed in tertiary medical centers and provide technical assistance to local hospitals. In addition, children's hospitals, March of Dimes, Ohio Hospital Association, and Children's Defense Funds are represented on the MCH Council.

BCMH has partnered with children's medical centers and pediatric specialists to continuously develop and refine standards of care, to meet emerging health and technological needs, and to facilitate the collaboration of health care providers and public programs, such as those housed in ODHS. Public health nurses promote family-centered, community-based, coordinated care. They link the tertiary care center team coordinator, local service providers, and families to develop a comprehensive plan that addresses the unique needs of the child and family.

Collaboration with Local Health Agencies A particular challenge will be to provide greater support to local health agencies as funding of direct health services lessens. Fortunately, BCMH had the foresight to create a Futures Committee as a forum for representatives of local health agencies to voice concerns about local and state policy as they impact families and communities. The local health agencies will require communication, training, technical assistance, and innovative funding as they conduct public awareness campaigns, provide direct services to families, and work to coordinate local systems for the benefit of families. The BCMH Field Nursing Consultant for each region is a key component of the program's ongoing infrastructure commitment.

Consultants in BCHSSD with expertise in nutrition, social work, school health, adolescent health, and community assessment are available for technical assistance. Some local health departments collaborate with programs as subgrantees (e.g., Abstinence Only Education).

Many local health departments are subgrantee agencies for county WIC programs. Due to this internal relationship, many health departments collaborate from within by referring participants to programs they administer. Collaborations include home health care, family planning, prenatal, well child, and immunization. If the WIC program is housed in the same building with other health department programs, one-stop shopping for participants is an additional benefit. Outreach efforts between the WIC program and the health department are common. Community events such as health and county fairs offer an opportunity to inform residents of available services that include the WIC program.

BOHS works with local health departments situationally. Collaboration usually centers on water fluoridation or local access program development.

Collaboration with The Ohio State University School of Public Health Two years ago, Title V staff collaborated with faculty members in OSU to explore the possibility of establishing a Department of Maternal and Child Health within the School of Public Health. Those discussions were put on hold, however, due to the resignation of the Dean of the College of Medicine, reorganization of the relationship between the School of Public Health and the College of Medicine, and the search for a Dean for the School of Public Health. More recently, faculty have inquired about renewing discussions concerning a distinct maternal and child health curriculum. In the meantime, Title V staff have provided formal oversight to physicians enrolled in the Preventive Medicine Residency and participate in the Residency Review Committee. Various Title V staff have assisted in teaching didactic components of classes within several colleges at OSU.

Two other public health programs are developing within Ohio: one through the Northeastern Ohio College of Medicine and one through a consortium of universities in northwestern Ohio. Title V staff remain open to working with these institutions, as well.

C. Provider Education

Hearing and Vision More than 1,000 health care providers in schools, health departments, and private practice settings were trained in SFY 1999 in the early identification, diagnosis, and treatment of children with hearing and vision disorders.

Lead Poisoning Prevention The Pediatric Lead Assessment NETwork (PLANET) pilot training program was implemented in SFY 1999 to increase the awareness and knowledge of health care providers about the health effects of lead poisoning, sources of lead, and Ohio's screening guidelines for high-risk populations.

Prenatal Smoking Cessation Almost 400 health care providers received training in SFY 1999 in the American Cancer Society's *Make Yours A Fresh Start Family* prenatal smoking cessation program. The goal of the program is to help women reduce or quit smoking while pregnant.

Denver II Developmental Screening Test Approximately 500 health care providers who administer developmental screenings were trained on the use of the DENVER II instrument. The DENVER II is designed to identify potential developmental problems in children. Twenty-five training sessions will be provided around the state.

SCHIP Outreach Almost 500 health care providers from DFCHS funded agencies received information through training and workshops about outreach strategies to enroll children into SCHIP.

School Nurse Program The school nurse consultant provides technical assistance, consultation, and continuing education to Ohio's estimated 1,200 school nurses. Through five annual ODH conferences, school nurses are provided with information to improve the quality of their practice in their local school systems. Approximately 800 school nurses attend the conferences annually. Through these school nurses, the information provided in the conferences has the potential to reach and affect all of the two million Ohio school children and their families.

3.2 Health Status Indicators

3.2.1 Priority Needs

A. Summary of Needs Assessment

The Needs Assessment Team used information about the health status of the MCH population gathered both as a result of the five-year needs assessment to generate a list of needs organized by the four levels of the pyramid.

Direct Health Care Services

1. Access for low-income women to high-risk perinatal and family planning safety net services
2. Access for low-income children and adolescents to dental care (including dental sealants)
3. Adolescent and family planning safety net services
4. Providers accepting Medicaid
5. Direct funding of payment for health care services for those portions not covered by other funding sources.

6. Special equipment for CSHCN
7. Home health care for CSHCN
8. Mental health services for CSHCN
9. Respite care for CSHCN
10. Specialized daycare for CSHCN
11. Nutrition services for CSHCN
12. Medical homes for CSHCN

Enabling Services

1. Assistance in the enrollment process for available health insurance plans
2. Targeted outreach efforts to bring high-risk women into early prenatal care
3. Culturally appropriate family planning materials
4. Prenatal smoking cessation programs
5. Programs that employ community health workers to improve access to care through culturally competent care coordination
6. Assistance in the enrollment process for available health insurance plans
7. Effective community-based outreach and enrollment strategies to ensure that children receive needed health care services through Medicaid/SCHIP
8. Information for families of CSHCN
9. Assistance with navigating benefits systems for families of CSHCN
10. Distance to specialty care

Population-Based Services

1. Public awareness about reproductive health and family planning services
2. Awareness among low-income women about the importance of early and continual prenatal care
3. Understanding among pregnant women of the harmful effects on the fetus from smoking during pregnancy
4. Public awareness about the following:
    - Overweight children and healthy eating and exercise
    - Community-based fluoride promotion
    - Health effects of childhood lead poisoning
    - Importance of early professional vision care for children
    - Importance of immunization schedule
    - Postponement of teen sexual activity
    - Proper use of safety devices to decrease motor vehicle deaths in children
    - Navigation of the health care system
    - Adolescent asset building models

- Risk factors for adolescent suicide

5. Educational materials on immunizations that are low literacy and culturally sensitive

Infrastructure Building Services

1. Information and training for providers on the following:
   - Breastfeeding
   - Factors contributing to low and very low birth weight
   - Culturally competent practices
   - Identifying populations at risk for poor birth outcomes
   - Domestic violence
   - Pediatric obesity
   - Oral health status, oral health resources, and access to dental care
   - Blood lead screening policy
   - Vision assessment
   - Screening and referral
   - Immunization schedule
   - Adolescent risk assessment inventories
   - Adolescent skill building and decision making models
   - Promotion of motor vehicle safety
   - Healthy Start/SCHIP information
   - Risk factors for adolescent suicide
   - Suicide prevention initiatives
2. Quality data and information for policy development and program planning on the following:
   - Smoking among pregnant women
   - Access to early prenatal care, including high-risk
   - Adequacy of prenatal care
   - Effective outreach strategies
   - Education needs of prenatal providers
   - Low and very low birth weight factors and trends
   - Rates of breastfeeding
3. A plan for a statewide system for infant, child, and adolescent death review
4. Information for legislators, policymakers, and MCH stakeholders on risk factors contributing to low birth weight and the effect of prenatal care on birth outcomes
5. Understanding among prenatal service providers of the barriers to care that pregnant women face.
6. Capacity among local public health agencies to conduct a community health assessment and planning process
7. A plan for a statewide system for infant, child, and adolescent death review

8. Quality data and information for policy development and program planning on the following:
   - Childhood lead poisoning prevention
   - Effective immunization outreach strategies
   - Contributing factors for teen pregnancy and low birth weight
   - Motor vehicle crashes
   - Rate of uninsured children served through safety net health care programs
   - Medicaid provider recruitment, training, and reimbursement
   - Uninsured rates for children
   - Medicaid eligible children receiving services
   - Barriers to Medicaid enrollment
9. Coordination/collaboration with ODHS regarding blood lead screening for Medicaid eligible children
10. Collaboration among public and private agencies to coordinate immunization planning efforts
11. Information for legislators, policy makers, and MCH stakeholders regarding contributing factors related to teen birth rates
12. Coordination among complex government programs.
13. Access to providers
14. Continuity of care with the established provider for CSHCN
15. Establishment of a network of providers in both urban and rural areas who are needed to diagnose and treat asthma and PDD
16. Availability of community PHN services
17. Comprehensive population-based data on CSHCN

B. Priorization of Issues

As described in Ohio's needs assessment methodology, prioritization was accomplished in two phases:

I. Separately for (a) maternal and infant, (b) child and adolescent, and (c) CSHCN populations (B.1)

II. Unified for the entire MCH population (B.2)

B.1 Issues Ranked in Priority Order in Phase I Needs Assessment Workshops

Maternal and Infant Health Issues Ranking
1. Very Low Birth Weight
2. Low Birth Weight
3. Perinatal Mortality
4. Births to Teens
5. Infant Mortality
6. Neonatal Mortality
7. Postneonatal Mortality
8. Neural Tube Defects

9. Maternal Mortality
10. Perinatal Transmission of HIV
11. Cesarean Sections

Child and Adolescent Health Issues Ranking
1. Oral Health Problems & Access to Dental Care
2 Overweight
3. Lead Poisoning
4. Tobacco Use
5. Alcohol Use
6. Teen Sexual Intercourse
7. Suicide Attempts
8. Vaccine-Preventable Diseases
9. STIs Ages 15 Through 19
10. Mortality Overall Ages 5 Through 14
11. Mortality Due to MV Crashes Ages 1 Through 14
12. Child Abuse and Neglect
13. Suicide Ages 15 Through 19
14. Mortality Overall Ages 1 Through 4
15. Anemia
16. Mortality Due to MV Crashes Ages 15 Through 24
17. Non-Fatal Injuries due to MV Crashes Ages 15 Through 24
18. Mortality Overall Ages 15 Through 19
19. Vision Problems & Access to Vision Care
20. Non-Fatal Injuries Due to MV crashes Ages 0 Through 15
21. HIV Ages 15 Through 19

Children with Special Health Care Needs Health Issues Ranking
1. Gaps in Services
2. Coordination of Individual Services
3. Lack of Population-Based Data
4. Medical Home
5. Genetic Services
6. Information to Families
7. Health & Safety in Child Care
8. Infant Hearing
9. Systems Barriers
10. Family Participation in Title V
11. Uninsured Served by Title V
12. SSI Served by Title V

B.2 Top Ten MCH Health Issues Identified in the Phase II Process (Unranked)

- The overall mortality rate of children and adolescents should be reduced.
- The incidence of low birth weight in infants should be reduced.
- The infant mortality rate should be reduced.
- The percentage of children and adolescents who are overweight should be reduced.
- The percentage of teens in grades 9 through 12 who have had sexual intercourse should be reduced.
- Policies and strategies should be implemented to facilitate coordination of services for CSHCN.
- The gaps in services for CSHCN should be eliminated.
- The percentage of children and adolescents who require oral health care and do not receive it should be reduced.
- The percentage of teens who use tobacco should be reduced.
- Population-based data for CSHCN should be established and maintained.

3.2.2 Data Analysis/Research Agenda

During the course of reviewing data as part of the needs assessment process, the Needs Assessment Team identified gaps in data and information that would have been helpful to better identify populations at risk and contributing factors toward which interventions could be developed. When such gaps in data were identified, they were noted. They since have been incorporated as strategies in the FFY 2001 MCH Block Grant and thereby represent the continual process of needs assessment that will be undertaken by DFCHS in the coming year. Listed below are gaps in data that were identified through that process and will formulate our research agenda for FFY 2001.

CPM 3, Medical Home

Conduct programmatic research and literature reviews to identify various methodologies used in the identification and quantification of children with special health care needs.

Research the validity of these methodologies, particularly the definition of CSHCN that was utilized to identify and quantify these children.

Collaborate with research and evaluation partners to determine the number of CSHCN in the state.

CPM 8, Motor Vehicle Death Rates (children ages 1 through 14)

Research available data sources, compare/contrast data components, and communicate results in order to identify at-risk populations, gaps in data, and opportunities for future programs.

CPM 11, CSHCN with a Source of Insurance for Primary and Specialty Care
Monitor data on enrollment rates of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

CPM 15, Very Low Birth Weight Live Births
Analyze association of Artificial Reproductive Technology, multiple births, and VLBW trends.

CPM 17, Very Low Birth Weight Infants Delivered at Facilities for High-Risk Deliveries and Neonates
Analyze current information regarding newborn survival rates at Level II and Level III hospitals by the following: specific birth weights and gestation; provider criteria for transfer of high-risk pregnancies to Level III facilities (e.g., referrals, use of transport); availability of high-risk services; cost of transport and care; and the impact of insurance/provider referral on transport practices.

CPM 18, Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester
Analyze current information on the women who are not getting care (e.g., defining subpopulations, cultural practices, geographic areas, insurance practices) in order to develop more effective outreach strategies.

SNPM, Unintended Pregnancy
Identify characteristics of Ohio women experiencing unintended pregnancy and contributing factors (e.g., use of birth control) and communicate results to legislator/policy makers, and Family Planning Stakeholders.

SNPM, Children with Elevated Blood Lead Levels as Defined by CDC
Develop a new science based high-risk blood lead screening policy.

SNPM, Racial Disparity in Perinatal Mortality Rates

Identify subpopulations in the Black population at risk for poor birth outcomes.

3.3 Annual Budget and Budget Justification

Summary Budget FY2001

Component A:	Services for Pregnant Women, Mothers and Infants up to age one year
Component B:	Preventive and Primary Care Services for Children and Adolescents
Component C:	Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs and their families.

Component A:	$	5,262,962
Component B:		9,872,733
Component C:		8,461,596
Subtotal:		
Administrative Costs:		821,311
GRANT TOTAL:	$	24,418,602

- Administrative costs are applied proportionally to Components A, B and C.

Budget Justification

Services for Pregnant Women, Mothers and Infants to Age One

In its FFY2001 request, Ohio has budgeted $ 59,645,349 for services for Pregnant Women, Mothers and Infants to Age One; 21.7 percent of the $ 275,054,247 total funds targeted for Title V related activities. For this component, MCH Block Grant funds total $ 5,262,962 or 21.5% of the $ 24,418,602 MCH Block Grant request. Other State and Federal funds for this component total $ 54,382,387or 21.7% of the budgeted $ 250,635,645 in other Title V related funds.

Level of Pyramid

Direct Health Care Services:

The FFY2001 Component A direct health care services budget is associated with State Negotiated Performance Measure 1 in the Annual Plan. Other funds designated for this function include State Child and Family Health Services Funds and WIC.

Enabling Services:

The FFY2001 Component A enabling services budget is associated with Core Performance Measure 5 for infants, and wrap around services provided by CFHS clinics through State Negotiated Performance Measure 1.

Population-Based Services:

The FFY2001 Component A population-based services budget is associated with Core Performance Measures 4, 5, 9, 10.

Infrastructure Building Services:
The FFY2001 Component A infrastructure building services budget is directly associated with Core Performance Measures 15, 17, 18 and State Negotiated Performance Measure 2.

Preventive and Primary Care Services for Children and Adolescents

In its FFY2001 request, Ohio has budgeted $ 178,916,726 for Preventive and Primary Care Services for Children and Adolescents or 65 percent of the $ 275,054,247 total of all funds designated for Title V and related activities. MCH Block Grant funds for this component total $ 9,872,733 which is 40 percent of the $ 24,418,602 MCH Block Grant request. Other State and Federal funds for this component total $ 169,043,993 or 67.5 percent of the $ 250,635,645 in other Title V related funds.

Level of the Pyramid

Direct Health Care Services:
The FFY2001 Component B direct health care services budget is associated with State Negotiated Performance Measure 7 in the Annual Plan. Other state and federal funds designated for this level include: State Child and Family Health Services funds.

Enabling Services:
The FFY2001 Component B enabling services budget is directly associated with State Negotiated Measure 5 in the Annual Plan.

Population-Based Services:
The FFY2001 Component B population-based services budget is associated with Core Performance Measures 5, 6, 7, 8 and State Negotiated Performance Measures 9 and 15.

Infrastructure Building Services:
The FFY2001 Component B infrastructure building services budget is associated with Core Performance Measures 13 and 16, and State Negotiated Performance Measures 2 and 12 in the Annual Plan.

Children with Special Health Care Needs

In its FFY2001 request, Ohio has budgeted $ 35,670,860 for activities for Children with Special Health Care Needs or 13 percent of the $ 275,054,247 of total funds budgeted for Title V and related activities. For this component, MCH Block Grant funds total $ 8,461,596 which is 34.7 percent of the $ 24,418,602

MCH Block Grant request. Other State funds for CSHCN total $ 27,209,264 or eleven percent of the $ 27,209,264 in other Title V related funds.

Level of the Pyramid

Direct Health Care Services:
FFY2001 Component C direct health care services budget is associated with Core Performance Measures 1 and 2, and State Negotiated Performance Measure 2 in the Annual Plan. The "other funds" designated for this level include: state subsidy; medically handicapped children audit funds; and the medically handicapped children county funds.

Enabling Services:
FFY2001 Component C enabling services budget is associated with Core Performance Measure 3 in the Annual Plan.

Population-Based Services:
The FFY2001 Component C population-based services budget is associated with Core Performance Measure 10 in the Annual Plan. The "other funds" designated for this level are from Ohio's federal Early Intervention grant.

Infrastructure Building Services:
The FFY2001 Component C infrastructure building services budget is associated with Core Performance Measures 11, 12, 13, and 14 in the Annual Plan.

Administrative Costs

Function	**MCH Funds**	**Other Funds**	**Total Budget**
Administrative	$ 821,311	0	$ 821,311

Maintenance of State Effort

In 1989, Ohio's MCH Block Grant award was $ 19,369,474 and the state provided $ 23,812,983 in support of the MCH activities. The fiscal year 2001 federal MCH award is expected to be $ 24,418,602 and the state will provide $ 34,060,367. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2001 are shown below.

Description		1989	2001
Sickle Cell Control	$	421,347	650,000
Genetic Services		1,144,281	703,771
Child & Family Health Services		5,652,423	8,860,121
Adolescent Pregnancy		400,000	0
Medically Handicapped Children		4,682,744	8,206,586
Cystic Fibrosis		325,394	0
Medically Handicapped Audit Funds		1,312,168	1,600,000
Medically Handicapped County Funds		9,874,626	14,039,889
Total	$	23,812,983	34,060,367

To determine the total amount of state match and funding of MCH programs, the Division of Family and Community Health Services totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations. The above Maintenance of Effort chart lists the 2001 state appropriations. The cystic fibrosis appropriation line item is no longer shown as match/maintenance of effort because it is dedicated to the provision of services to adults with cystic fibrosis. Services for children with cystic fibrosis are supported by other state CSHCN funds. One million, seven hundred thousand ($1,700,000) of the state Child and Family Health Services appropriation is not included as match for the Title V award because it is designated as part of the Title X Family Planning Project. The funds are include in the application , as are the Title X funds, as “Other Funds” (line 15e of form 424) State Family Planning Non-Match under Component A. Ad additional $600,000 of the CFHS appropriation is set-aside for Federally Qualified Health Centers and is not included on Form 424, Line 15c as match to Title V funds. These funds are included in Line 15e because the population to be served is broader than the population served by MCH funds.

Rate Agreement

STATE AND LOCAL DEPARTMENT/AGENCIES

EIN NO: 1-316402047-A1

DEPARTMENT/AGENCY:	Ohio Department of Health 246 North High Street P.O. Box 118 Columbus, Ohio 43266-0118	Date: September 1, 1994 FILING REF: The preceding Agreement was dated 12/11/92

The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section II.

SECTION I: INDIRECT COST RATES

Type	From	To	Rate	Locations	Applicable to
Fixed	7/1/91	6/30/93	36.0%	All	All Programs
Fixed	7/1/93	6/30/94	31.8%	All	All Programs
Fixed	7/1/94	6/30/95	33.7%	All	All Programs
Provisional	7/1/94				

Until amended, use same rates and conditions as those cited for fiscal year ending June 30, 1995.

Treatment of fringe benefits: Fringe benefits are specifically identified to each employee and are charged individually as direct costs. The directly claimed fringe benefits are listed in the Special Remarks Section of this agteement.

Administrative Costs:
The administrative costs of Ohio's 2001 MCH Block Grant request are based on budget and expenditures related to the Operations Section of the Bureau of Health Services Information and Operational Support. The Operations Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs. In FFY99, an administrative time study was conducted. The goal of the study was to measure the time spent by administrative staff supporting activities of the Division of Family and Community Health Services (where Title V funds are administered) for all major funding sources. The department is currently engaged in a time study for state fiscal year 2000. The results of this study may be reflected in the FFY2002 application. The Department will continue to use time management studies to assure proper allocation of administrative costs by program and funding source.

FFY2001 Carry Over Funds:
The amount of carryover funds is based on the total amount of funds available in 2000 less projected expenditures and encumbrances as recorded through February 2000. In FFY2000 a total of $ 28,817,714 in MCH Block Grant funds were available to the State of Ohio. According to the Department's accounting reports, which reflect activity through February 2000, projected expenditures and encumbrances to be posted against FFY2000 MCH funds will total $ 23,011,303. When total available funds are reduced by total project expenditures and encumbrances, the Division expects to have an unencumbered balance of $ 5,806,411.

The Ohio Maternal and Child Health Programs supports the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to able state MCH agencies to provide stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the lapsed amount is equal to approximately one quarter's expenditures. This has allowed Ohio to provide continuity of services to our local partners who otherwise could be forced to interrupt service while awaiting a new NOA.

PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home".		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first				X			X

trimester.							
STATE NEGOTIATED PERFORMANCE MEASURES							
1) The unintended pregnancy rate per thousand in women of childbearing age.	X						X
2) Development of the role of the new Genetics in public health programs.				X		X	
5) The percentage of low income children who are overweight.		X					X
7) Percent of third grade children with obvious need for dental care.	X						X
9) The percentage of children with elevated blood lead levels as defined by the Centers for Disease Control and Prevention.			X		X		
11) The low birth weight rate (LBW) per 100 live births.			X				X
12) Implementation of a statewide Child Fatality Review (CFR) System.				X	X		
13) The ratio of black perinatal mortality rate to the white perinatal mortality rate.			X				X
14) The reported cases of physical assault by current or former intimate partners (domestic violence).			X				X
15) Percentage of children in Kindergarten and 1st grade failing a vision screening.			X				X

3.4.2.2 Discussion of State Performance Measures

After the needs assessment process was complete, i.e., data had been reviewed, focus groups held, surveys conducted, and advisory councils met, a list of Ohio's MCH priorities was determined. In order to plan MCH Block Grant activity, the priority areas were compared with the required 18 Core Performance Measures. Programmatic activity is required for the 18 Core Performance Measures, so those issues were set aside. Two issues were identified as being addressed through other ODH programs, and through programs in other state agencies; the remaining priority issues were then framed into State Negotiated Performance Measures. Each state negotiated performance measure represents a health issue identified as a need through Ohio's needs assessment.

Each level of the pyramid is represented through Ohio's State Negotiated Performance Measures with five of the measures being population-based services; two each falling into the categories of direct health care services and infrastructure building; and one measure in the enabling services. Many of the Ohio's State Negotiated Performance Measures are "gap filling" services; issues not addressed through Core Performance Measures, and yet still identified health needs in the state.

Several of the State Negotiated Performance Measures are directly linked with the required Outcome Measures, and the one State Negotiated Outcome Measure. These measures will be monitored very closely and analyzed with the strategies and activities conducted to impact them.

4.1 Program Activities Related to Performance Measures

Direct Health Care Services

Pregnant Women, Mothers, Infants

State Negotiated Performance Measure 1

The unintended pregnancy rate per thousand in women of childbearing age.

A. Fund, monitor, evaluate and provide technical assistance to local family planning agencies.
B. Build skills among providers to empower women to protect themselves with awareness, knowledge, skills and other methods from peer pressure, coercion, rape, influences to use drugs, etc.
C. Identify programs and interventions that encourage male involvement and communicate best practices to DFCHS funded agencies.
D. Identify characteristics of Ohio women experiencing unintended pregnancy and contributing factors (e.g., birth control usage) and communicate results to legislators/policy makers, and Family Planning Stakeholders.
E. Research and purchase more culturally appropriate family planning materials.

F. Partner with other educational institutions to encourage culturally diverse, culturally competent family planning providers.

G. Provide consultation, technical assistance and training opportunities on abstinence education to state and local agency staff.

Children

State Negotiated Performance Measure 7

The percent of third grade children with obvious need for dental care

A. Fund, monitor, and evaluate dental safety net programs and help build the infrastructure of safety net dental care programs in Ohio.

B. Collaborate with the Ohio Dental Association to coordinate and monitor OPTIONS, the statewide dental care access program for Ohioans with no form of dental insurance and limited resources to pay for care.

C. Maintain current statewide data on oral health status, oral health resources and access to dental care for statewide planning and continue to provide data to communities for local needs assessment.

D. Increase access to oral health care services by creating local partnerships, planning oral health initiatives, and developing new systems that increase access to care.

E. Build the capacity of local agencies and health care providers to assess the oral health needs and resources of their clients and implement strategies to meet those needs.

F. Utilize the existing system of school-based sealant programs and OPTIONS to enroll vulnerable children in Medicaid and SCHIP and implement school-based strategies to ensure children receive needed care.

G. Prevent dental caries through community-based fluoride promotion (i.e., community-based water fluoridation and school-based fluoride mouth rinse programs).

H. Implement the strategic plan developed by the Director's Task Force on Access to Dental Care.

Children with Special Health Care Needs

Core Performance Measure 1

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

A. Obtain data to match SSI and BCMH recipient files and update BCMH case information on SSI status.

B. Develop data base to track referrals from the Bureau of Disability Determination and a mechanism to identify those potentially eligible for BCMH outreach.

C. Develop a collaborative strategy between BCMH and BEIS for outreach to new SSI beneficiaries at the community level.

Core Performance Measure 2

The degree to which the state CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

A. Pay for eight of nine services on the checklist: medical and surgical subspecialty services; occupational therapy; physical therapy; speech therapy; respiratory services; durable medical equipment and supplies; nutrition services; and care coordination services for financially eligible children with a medically handicapping condition.

B. Explore the feasibility of expanding coverage of home health care associated with complex and debilitating conditions. (Focus on those most likely to require institutionalization or home care.)

C. Pay private insurance premiums for BCMH clients when deemed cost-effective to allow families to access additional treatment options, including specialty and subspecialty care.

D. Fund a statewide network of specialty clinics to provide cardiac, developmental delay, hearing, neurology, orthopedic, plastic surgery and vision services in medically underserved areas of the state.

E. Train individuals in hearing and vision screening practices through conferences and training sessions.

Enabling Services
Children

State Negotiated Performance Measure 5

The percent of low income children who are overweight.

A. Monitor birth weight and growth of children through WIC (via PedNSS and PNSS) and MATCHr data.

B. Develop an in-house data quality assurance system to assess consistency in data reported via WIC, PedNSS, PNSS and MATCHr.

C. Provide technical assistance to DFCHS funded agencies with high percentages of overweight infants and children.

D. Collaborate among state and local programs/organizations (especially ODH Division of Prevention) to promote healthy eating and exercise/active play.

E. Disseminate and encourage use of parenting materials developed during FFY2000 to promote healthy eating and active play (via conferences, newsletters and technical assistance visits).

F. Disseminate recommendations on prevention, evaluation and treatment of pediatric obesity, developed by a Maternal and Child Health Bureau Expert Committee, to physicians, nurse practitioners and dietitians/nutritionists.

Children with Special Health Care Needs

Core Performance Measure 3

The percent of Children with Special Health Care Needs in the State who have a "medical/health" home.

A. Conduct programmatic research and literature reviews to identify various methodologies used in the identification and quantification of children with special health care needs.

B. Convene a work group comprised of state CSHCN program administrators, statisticians, epidemiologists and parents of CSHCN to discuss research findings and make recommendations.

C. Collaborate with research and evaluation partners to determine the number of CSHCN in the state.

D. Require managing physicians to be qualified to manage the specific condition for the child on the BCMH Program.

E. Pay new physician case management CPT codes for specific services for children enrolled on the BCMH Program.

F. Survey families with children with special health care needs not on BCMH regarding their perception of their medical home.

G. Collaborate with BEIS to promote the concept of a medical home.

H. Analyze available data to determine the quality of medical home.

I. Coordinate with the National AAP and the Ohio AAP regarding their medical home project.

J. Increase the availability of information to physicians, families and others who enable the function of a good medical home.

Population-Based Services
Pregnant Women, Mothers and Infants

Core Performance Measure 4

Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [e.g., the sickle cell disease) (combined)]

A. Define follow-up for ODH sponsored sickle cell and genetics programs and ensure that Regional Centers are informed of their responsibilities regarding follow-up.

B. Monitor visits made to, and activities of, ODH funded Regional Genetics and Sickle Cell Centers through site visits and data collection.

C. Collaborate with staff at the ODH Laboratory in assuring a continuum of services to families from the time of newborn screening, identification, treatment, and follow-up.

Core Performance Measure 9

The percent of mothers who breastfeed their infant at hospital discharge.

A. Monitor MATCHr, WIC and other data sources documenting breastfeeding rates.

B. Observe World Breastfeeding Week, August 1-7, 2001.

C. Update/implement ODH Breastfeeding Policy in CFHS and WIC clinics.

D. Provide a CFHS/WIC sponsored statewide "Back to Basics" Breastfeeding training.

E. Promote the formulation of Breastfeeding Task Forces at the local level.

F. Work with other educational and professional groups (e.g., hospitals, ODH Breastfeeding Committee, and Regional Perinatal Centers) to promote Breastfeeding.

G. Sponsor a workshop to teach the "3 Step Training" to WIC/CFHS professionals.

Core Performance Measure 10

Percentage of newborns who have been screened for hearing impairment before hospital discharge.

A. Implement the current risk-based program while planning and beginning implementation of universal newborn hearing screening (UNHS).

B. Establish committees of the UNHS stakeholder group to develop protocols for newborn hearing screening, tracking and follow-up care.

C. Provide training and technical assistance to hospitals establishing UNHS programs, emphasizing Ohio's fifteen hospitals with tertiary newborn intensive care units.

D. Increase public awareness about the need for newborn hearing screening and appropriate follow-up.

E. Monitor legislative action related to universal newborn hearing screening.

F. Contract with individual/vendor to develop interactive distance training program.

G. Contract with individual/vendor to analyze Ohio's need for a comprehensive data collection, reporting, and tracking system.

State Negotiated Performance Measure 11
The low birth weight rate per 100 live births.

A. Collaborate with partners to reduce smoking among pregnant women by prohibiting smoking in public places; increasing cigarette tax; decreasing access to cigarettes; and enforcing ciragette-purchasing restrictions.
B. Increase prenatal smoking cessation programs.
C. Assess and then triage women in DFCHS funded agencies that are at high risk for low birth weight into more intensive follow-up and counseling.
D. Collaborate with the Office of Women's Health, Women's Health Program (in Division of Prevention) to support reproductive health through comprehensive population-based health education.
E. Fund affordable and comprehensive family planning services to assure that women are healthy before becoming pregnant.
F. Educate legislators, policy makers, and MCH stakeholders on health problems and risk factors associated with low birth weight.
G. Provide technical assistance to DFCHS funded agencies on the emotional, behavioral, cultural, and nutritional factors that contribute to low birth weight.

State Negotiated Performance Measure 13
The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

A. Identify sub-populations in the African American population at risk for poor birth outcomes.
B. Assist and support DFCHS funded clinics to implement culturally competent practices in the community setting and to institutionalize these changes in practice.
C. Collaborate with the Ohio Commission on Minority Health to adopt policies at ODH that define and mandate culturally competent practices.
D. Expand programs that employ community health workers to improve access to care through culturally competent care coordination, and other social support.
E. Develop culturally competent care coordination services through the postpartum period in every CFHS clinic that transfers prenatal patients out before the end of the pregnancy.
F. Develop culturally relevant interventions for identified sub-populations.
G. Gather data about community resources and their assets in reducing infant mortality.
H. Raise community awareness of the disparity issues to build commitment in reducing the disparity by mobilizing the community.

State Negotiated Performance Measure 14

The cases of physical assaults by current or former intimate partners (Domestic Violence).

A. Train all Division programs to identify Battered Women's Syndrome.

B. Assess the capacity of health care providers in DFCHS funded agencies to assess domestic violence, adhere to protocol, and provide appropriate referrals for women to resources.

C. Educate providers in DFCHS funded agencies and school nurses with the legal system's application of penalties and adjudication regarding domestic violence.

D. Collaborate with state agencies to develop and disseminate resources on healthy relationships and reducing risk factors for domestic violence.

E. Provide resources and training for providers that serve adolescent women about date violence.

Children

Core Performance Measure 5

Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

A. Provide low literacy, culturally sensitive education regarding immunizations for hard-to-reach population groups (e.g., African American; and families/parents with low education levels).

B. Provide information to health professionals regarding the importance of immunizations; current immunization schedule; how to maximize immunization opportunities; and immunization contraindications.

C. Research what immunization outreach strategies are successful and communicate the best practices to providers, clinics, etc.

D. Monitor data quality within the DFCHS.

E. Collaborate with internal (e.g., Division of Prevention) and external health professionals to improve the state immunization rates by sharing resources and coordinating planning efforts.

F. Conduct a statewide public education campaign regarding the immunization schedule and need for immunizations.

G. Develop specific interventions for updating immunizations among infants in NICUs.

Core Performance Measure 6

The rate of births (per 1000) for teenagers aged 15 through 17 years.

A. Identify and communicate best practices to DFCHS funded projects regarding clinics that serve adolescents (e.g., CFHS and other community-based clinics).

B. Identify and communicate results regarding model risk assessment inventories that identify at risk adolescents to DFCHS funded agencies.

C. Identify successful skill building models (e.g., mentoring, peer training) and communicate best practices to DFCHS funded projects.

D. Partner with community and parent groups (e.g., abstinence only education programs) to encourage age-appropriate adolescent health programs that encourage responsible reproductive health decision-making.

E. Educate legislators, policy makers, community leaders, local programs, and agencies regarding contributing factors (e.g., lack of access, confidentiality) relating to birthrate to teens ages 15-17.

F. Collaborate with DFCHS funded agencies and other public health agencies to encourage teen sexual activity postponement.

G. Fund, monitor, evaluate and provide technical assistance to family planning sites to ensure quality service.

H. Identify hard-to-reach teen populations and contributing factors for teen pregnancy, and communicate results with DCFHS funded projects.

I. Collaborate with Ohio's Abstinence-Only Education Programs to share resources and materials and to promote training opportunities for state and local agency staff.

Core Performance Measure 7

Increase the percentage of third graders who have received protective sealants on at least one permanent molar tooth.

A. Expand school-based and school-linked dental sealant programs to reach additional high-risk elementary schools in Ohio.

B. Fund, monitor and provide consultation and technical assistance to 15 currently funded local agencies operating school-based dental sealant programs.

C. Conduct SPRITE (Sealant Program Review for Improving Team Efficiencies), a peer review process for sealant subgrantees to continually improve the quality of services and to provide opportunities to share information and successful programmatic and clinical practices.

Core Performance Measure 8

The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

A. Coordinate with private and public agencies to participate and promote statewide education to increase awareness and proper use of safety devices, with a focus on booster seats, to decrease the rate of motor vehicle deaths in children ages 1-14 years.

B. Provide education to providers (e.g., local health departments, hospitals, child care centers, law enforcement, human services providers) of the importance of safety devices, the proper use of safety devices, the provider's role in promoting motor vehicle safety as well as available resources.

C. Research available data sources, compare/contrast data components and communicate results in order to identify at-risk populations, gaps in data, and opportunities for future programs.

State Negotiated Performance Measure 9
The percent of all children with elevated blood lead levels as defined by CDC.

A. Increase awareness in public and parent populations on the health effects of childhood lead poisoning, especially the effects of nutrition and proper house cleaning on lead poisoning.
B. Increase compliance with blood lead screening standards and follow-up of confirmed cases by physicians.
C. Collaborate with ODHS to increase screening of Medicaid eligible/enrolled children.
D. Increase primary prevention efforts through collaboration with community-based organizations.
E. Coordinate with inter-agency and intra-agency partners to plan, coordinate and implement program strategies and activities in support of childhood lead poisoning prevention.
F. Develop new risk factors to be used in addition to the current factors to identify high risk geographic areas to target childhood lead screening efforts.
G. Decrease the disparity of lead poisoning in racial, ethnic and cultural groups.

State Negotiated Performance Measure 15
The percentage of children in Kindergarten and 1st grade failing a vision screening.

A. Improve and increase training on vision assessment and referral for primary care providers.
B. Increase utilization of existing vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services.
C. Increase compliance with preschool vision screening standards of the Ohio Department of Health.
D. Develop a statewide unified preschool vision screening data collection system which would be linked to and support an existing children's eye injury data collection system.
E. Increase public (parent) awareness of the importance and need for early professional eye care for children.
F. Collaborate with ODHS and ODE to include a vision screening prompt on the annual medical evaluation form for child day care centers.

Infrastructure Building

Pregnant Women, Mothers and Infants

Core Performance Measure 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

A. Fund and monitor regional perinatal outreach and education program to
   -identify the education needs of prenatal providers
   -evaluate the data from prenatal services in their regions
   -evaluate the education needs identified through quality assurance reviews.

B. Analyze current information regarding newborn survival rates at Level II and Level III hospitals by: specific birth weights and gestation; providers criteria for transfer of high-risk pregnancies to Level III facilities (e.g., referrals, use of transport); availability of high-risk services; cost of transport and care; and the impact of insurance/provider referral on transport practices.

C. Monitor use of prenatal care risk assessment in CFHS Prenatal Clinics so women who are at risk are referred to high risk facilities.

Core Performance Measure 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

A. Assure that access to prenatal care is analyzed in CFHS community health assessment and planning processes.

B. Analyze current information on who is not getting care (e.g., defining sub-populations, cultural practices, geographic areas, insurance practices) in order to develop more effective outreach strategies.

C. Conduct targeted outreach to bring high-risk women into WIC and prenatal care in the first trimester.

D. Raise awareness among women of the importance of early prenatal care in DFCHS funded agencies.

E. Education legislators, policy makers and MCH stakeholders on the effect of early prenatal care on birth outcomes.

F. Fund, monitor and provide technical assistance to CFHS projects.

G. Analyze entry into prenatal care in CFHS projects by race and whether the CFHS projects are serving the African American populations in their communities.

H. Analyze the adequacy of prenatal care as measured by the Kotelchuk Index.

Core Performance Measure 15

Percent of very low birth weight live births

A. Fund, monitor and provide technical assistance to CFHS prenatal clinics.
B. Provide technical assistance to CFHS projects on the biological and environmental factors that affect VLBW (e.g., douching, bacterial vaginosis); who is at risk for VLBW; the contributing factors and compare to the risk factors for LBW.
C. Monitor the use of a risk assessment tool with all prenatal clients in CFHS funded prenatal clinics.
D. Analyze association of Artificial Reproductive Technology, multiple births and VLBW trends.
E. Work with Ohio Section of ACOG to identify additional strategies.
F. Plan to involve RPECs in future activities.

State Negotiated Performance Measure 2

Development of the role of the new Genetics in public health programs.

A. Director of Health to convene a Task Force to examine implications of Human Genome Project for public health.
B. Fund, monitor and evaluate regional Genetics counseling and evaluation centers in Ohio.
C. Evaluate and revise programmatic policies based on Task Force recommendations as appropriate.

Children

Core Performance Measure 12

Percent of children without health insurance.

A. Educate and improve the quality of data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.
B. Educate consumers to understand and navigate the health care system.
C. Collaborate with intra-departmental, state, local agencies, and initiatives (ODHS, ODE< OFCF, Ohio Commission on Minority Health) to publicize and disseminate Healthy Start information to providers, consumers and employers.
D. Work with ODHS to assess issues regarding provider recruitment, training, and reimbursement.
E. Provide technical assistance to DFCHS funded agencies and DFCHS staff on the changes in the Healthy Start Program.
F. Determine funding mechanism for collecting and reporting from an ongoing data sources on uninsured children, e.g., Ohio Family Health Survey.
G. Identify and assist communities in using VISTA volunteers to conduct community-based Medicaid/SCHIP outreach efforts.

Core Performance Measure 13

Percent of potentially Medicaid eligible children who received a service paid by the Medicaid program.

A. Determine mechanism and data source for reporting and collecting "potentially eligible" Healthy Start children (e.g., data from ODHS, Ohio Family Health Survey, Census).

B. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid program.

C. Identify and report factors that explain why children are not getting enrolled in Healthy Start and why the enrolled children are not getting services.

D. Collaborate with ODHS to assess provider issues such as training, recruitment and reimbursement.

E. Collaborate with intra-departmental, state, local agencies and initiatives (ODHS, ODE, OFCF, Ohio Commission on Minority Health) to publicize and disseminate Healthy Start information to providers, consumers and employers.

Core Performance Measure 16

The rate (per 100,000) of suicide deaths among youths aged 15-19.

A. Gather data on community resources and youth/adult perceptions and report on communities engaged in asset building.

B. Raise community awareness of the asset building model.

C. Develop collaborative teams of stakeholders (internal and external) to build commitment, gather information, set priorities, and plan for suicide prevention initiatives.

D. Raise awareness of providers/clinicians and the public to the warning signs, symptoms, and risk factors for adolescent suicide and the need to engage adolescents in these discussions as necessary.

E. Identify barriers and access to health care as well as available resources.

F. Collaborate with the Ohio Department of Mental Health in implementing strategies.

State Negotiated Performance Measure 12

Implementation of a statewide Child Fatality Review (CFR) System

A. Develop an initial plan for implementation of a statewide system for infant, child, and adolescent death review using technical assistance arranged for by MCHB.

B. Convene a state level CFR team with community representation to continue planning for implementation of a statewide system of infant, child and adolescent death review.

C. Work with state level CFR team to develop standardized protocols for community-based CFR teams.

D. Work with state level CFR team to develop training materials, manuals and training sessions for community-based CFR teams.

E. Work with state level CFR team to review annual reports from community-based CFR teams and prepare and disseminate a report on child fatalities in Ohio.

F. Encourage all Ohio counties to implement a CFR system, whether individually as a county, or regionally.

G. Identify funding for community-based CFR activities.

Children with Special Health Care Needs

Core Performance Measure 11

Percent of Children with Special Health Care Needs (CSHCN) in the State Program with a source of insurance for primary and specialty care.

A. Pay health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services.

B. Develop mechanism for payment of Healthy Start (SCHIP) premiums.

C. Identify potentially eligible Health Start (SCHIP) children on the treatment program; provide information to their families; and assure that enrollment assistance is available if needed.

D. Develop collaborate between BCMH, BCFHS, and BEIS for outreach to uninsured children identified through Specialty Clinics, BCMH diagnostic and Early Intervention Programs.

E. Monitor data on enrollment rates of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

F. Monitor data on Healthy Start/Medicaid drop-off and intervene in a timely manner and analyze reasons for drop-off.

G. Assess data quality and availability issues.

Core Performance Measure 14

The degree to which the State assures family participation and policy activities in the State CSHCN Program.

A. Expand the membership of the Parent Advisory Council.

B. Plan to increase

-cultural diversity in the Parent Advisory Council

-parent participation in staff training activities

-family involvement in the MCH Block Grant process

-financial support for parent activities or parent groups

-family member participation on more advisory committees and task forces

C. Employ a second Parent Consultant.

D. Survey parents regarding their perceptions of the BCMH parent consultant, Parent Advisory Council, communication with parents, and service gaps.

4.2 Other Program Activities

The DFCHS coordinates activities with many other maternal and child health-related programs through responsibility as the Title V administrator. Other programs related to Title V but funded through other sources include WIC, Title X Family Planning, Abstinence Only Education and CDC-funded Childhood Lead Poisoning Prevention Programs.

DFCHS operated the Help Me Grow (HMG) Helpline, a toll free 800 number, which provides health and social service referrals and information to callers. Information on programs from the following state agencies is currently available: Aging, Alcohol and Drug Addiction Services; Health; Job and Family Services (formerly Human Services); Mental Health; Mental Retardation and Developmental Disabilities, as well as local sites for service delivery.

DFCHS participated with the ODH Women's Health Section to promote education within the Department and local communities around domestic violence issues. Staff also participated on the Women's Health Leadership Conference to address the policy issues related to domestic violence. The DFCHS Chief serves on the Children's Trust Fund Board which addresses issues of child abuse and neglect.

DFCHS staff participate in several workgroups with the Ohio Department of Job and Family Services (formerly Human Services) to collaborate on activities that include: revising the Combined Programs Application; reviewing county outreach plans requesting funds allocated through the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996; identifying outreach best practices among local agencies via mail survey and site visits; and designing an evaluation plan to measure the impact of outreach and coordination activities in increasing the number of children enrolled in health care coverage.

DFCHS outreach activities for access to Medicaid/Healthy Start include:

- Help Me Grow promoted Ohio Healthy Start to consumers through distribution of wellness guides;
- Outreach information for Medicaid was distributed through workshops, mailings, and project directors meetings in CFHS, EI and WIC Programs; and
- BCMH requires all potentially eligible families to apply for Medicaid before enrollment in BCMH.

4.3 Public Input

Literally hundreds of individuals provided input into Ohio's FY2001 MCH Block Grant application. State legislators, state agency directors, Governor's Office staff, DFCHS staff, local health commissioners, consumers of MCH Block Grant funded services, and the general public all participated in components of the comprehensive needs assessment. On May 8, 2000, the MCH Council met to review the Annual Report for FY99 and the draft FY2001 block grant application.

Three public hearings were held on June 7, 8, and 9, 2000 in Columbus, Cleveland and Cincinnati respectively. To publicize the hearings, legal notices were printed in Ohio's seven major newspapers, including one paper targeting the African American community; and the ODH Office of Public Affairs was sent information about the hearings and announced them as part of their routine department publicity. In addition, over 500 letters announcing the hearings were sent to all Division program areas, including those funded by MCH Block Grant funds, and those funded through other sources.

Approximately 25 individuals provided testimony at the three public hearings. All testimony provided was in support of Ohio's MCH Block Grant activities. Specific topics addressed in the testimony were childhood lead poisoning; pediatric specialty clinics; WIC; breastfeeding; family planning services; child death review; infant mortality reduction initiatives; and support of MCH programs in general specific to the individual's county. One individual from academia provided testimony in support of Ohio's MCH activities from an epidemiological perspective. The testimony provided, and other letters of support are included in the Appendix.

To encourage further public review, copies of the application will be sent to the State Library of Ohio Document Administrator with instructions to send copies to 50% of the legislative depository public libraries throughout Ohio to make the application available for public review. Also, the MCH Block Grant will be placed on the ODH Home Page to enhance public access. Additionally, the general public may have access to the complete application during regular business hours from 7:45 am to 4:30 pm at:

Ohio Department of Health
Division of Family and Community Health Services
246 North High Street
Columbus, Ohio 43215

Ohio's MCH Block Grant application is also reviewed by a joint legislative committee made up of five state representatives and five state senators. The committee held a hearing to gather testimony on the application as well.

Consumers and health professionals in 2,500 Ohio agencies will have access to the application through the Ohio Health Promotion Network. Health professionals may borrow the application through the network and consumers may view the document at the ODH Library during regular business hours. The application is available for public input throughout the year. DFCHS will respond to any suggestions received and revise the application if deemed appropriate.